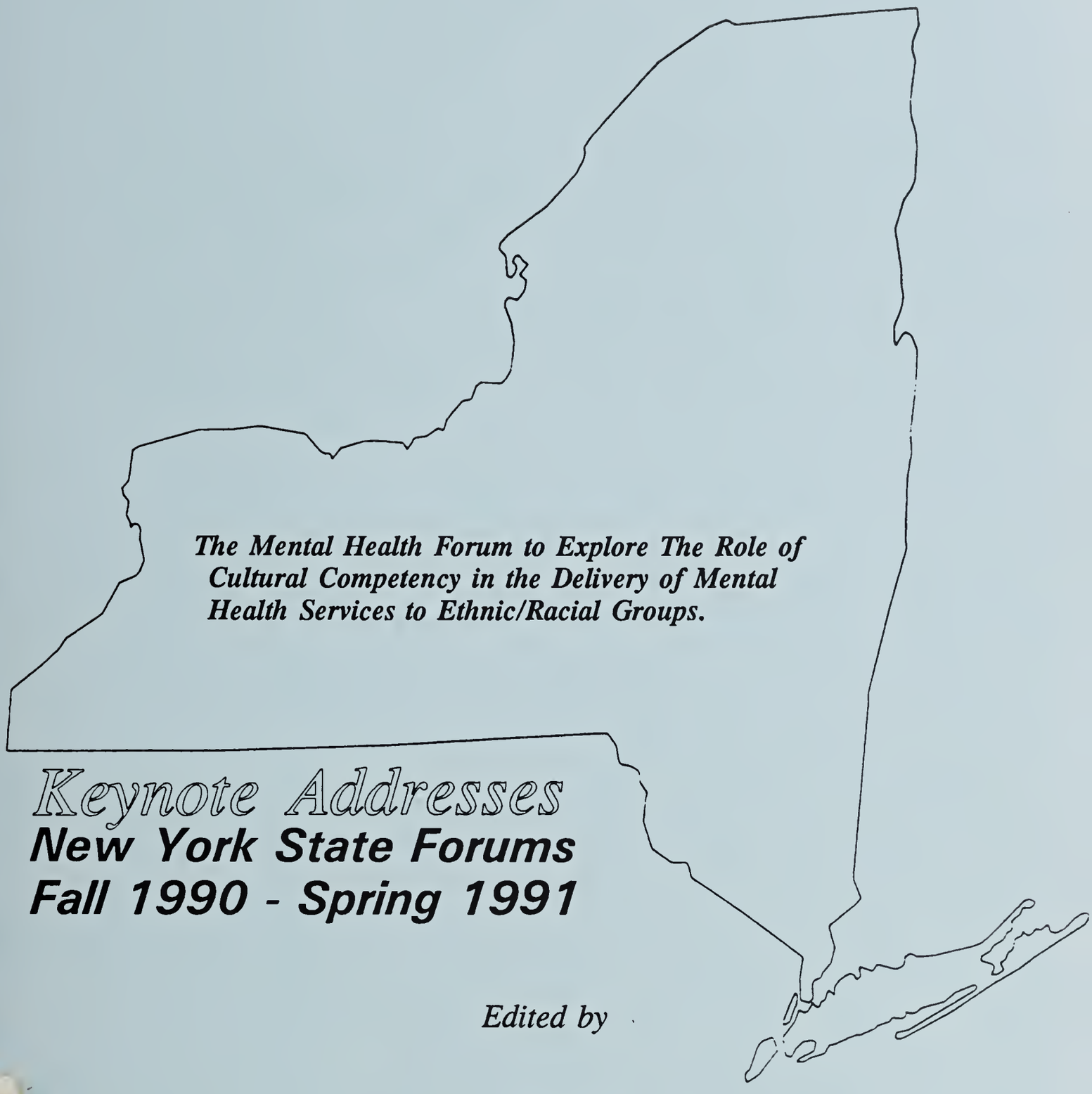

The Mental Health Forum to Explore The Role of Cultural Competency in the Delivery of Mental Health Services to Ethnic/Racial Groups.

Keynote Addresses
New York State Forums
Fall 1990 - Spring 1991

Edited by

Joseph Suarez, Ph.D.

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MULTICULTURAL EDUCATION, RESEARCH AND TRAINING INSTITUTE
at Metropolitan Hospital Center in Affiliation with New York Medical College

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A MERTI PUBLICATION

M.E.R.T.I.

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Keynote Addresses

Table of Contents

Introduction.....1

1. Central New York Region: **Howard Blue, M.D.**, Assistant Professor of Psychiatry, Yale University, School of Medicine.....3

The Historical Perspective
The Role of Cultural Competency in the Delivery of Mental Health Services

2. New York Region: **Pedro Ruiz, M.D.**, Professor of Psychiatry, Baylor College of Medicine..... 27

The Personal Perspective
Public Psychiatry and Ethnic/Racial Minorities

3. Long Island Region: **Hugh F. Butts, M.D.**, Attending Psychiatrist, Beth Israel Hospital..... 47

The Clinical/Therapeutic Perspective
Significance of Ethnic, Racial and Cultural Diversities in Psychiatric Treatment

4. Hudson River Region: **Billy Jones. M.D.**, Commissioner, Department of Mental Health, Mental Retardation and Alcoholism Services, New York City.....73

The Administrative Perspective
Minority Mental Health Needs and Priorities

5. Western Region: **Arthur O. Eve, Assemblyman**, 141st Assembly District, Deputy Speaker of the Assembly, Erie County.....93

The Legislative Perspective
The Current Budget War and Its Impact on Minority Mental Health Care

Keynote Addresses

INTRODUCTION

Cultural diversity is not new to the American scene. It dates back to a time in history when the continent was homeland to a variety of tribes. Each had its own distinctive culture which developed over centuries prior to what Henri Mann (Mann et al, 1991) refers to as the "time of contact". Following contact and subsequent colonization of the Americas as part of the European and later United States manifest destiny, the concept of cultural diversity took on a dimension of relative value. This conceptualization developed and fostered by the colonization of White Europeans placed the highest positive value on their antecedent cultural traits, mores, expected behaviors and beliefs. The non-White cultures (notably Indian and Black) were denigrated to inferior status.

Consequent attempts to develop an indigenous American culture through operationalization of the melting pot theory proved to be a failure. In spite of its vaunted cultural integration claims, the melting pot theory was basically exclusionary with little or no attempt made to accommodate people of color. Relegated to a stance of relative cultural isolation, ethnic/racial populations continued to maintain and evolve their cultural heritage, identity and institutions while concomitantly participating at the periphery of the dominant white culture. The vicissitudes of such isolation are clearly evident in the magnitude of social and mental health problems which ethnic/racial populations manifest and the manner in which health and mental health systems are organized to deliver necessary preventive and treatment programs to minority communities.

Cognizant of the cultural dissonance between mental health professionals and the ethnic/racial composition of New York State mental health clientele, a series of Forums were commissioned state wide by the Office of Mental Health during fiscal year 1990-1991. The keynote addresses for all of the Forums presented here served as a frame of reference for discourse during the meetings. The experiences, concepts, thoughts and issues addressed in the presentations included the significance and impact of cultural diversity in assessment, diagnosis, treatment and management of ethnic/racial patient populations; cultural clash as an impediment to appropriate mental health care delivery; establishment of priorities for addressing minority mental health needs; and the politics of minority mental health care.

The value of this document is not a casual one time perusal of its content but in its repeated readings. Hopefully, subsequent readings will provide new insights into a very complex and multifaceted set of issues and problems for the reader.

Joseph Suarez, Ph.D.

Director
Multicultural Education, Research and Training Institute

CENTRAL REGION

SYRACUSE, NEW YORK

October 9, 1991

THE ROLE OF CULTURAL COMPETENCY IN THE DELIVERY OF MENTAL HEALTH SERVICES

HOWARD BLUE, M.D.

YALE UNIVERSITY
SCHOOL OF MEDICINE

It is indeed an honor to be here today to address this extraordinarily important topic. I wish to thank the organizers of this Forum for inviting me. As both a clinician and an African American, this topic has long been an issue that has generated much thought and, at times, much frustration, I believe the tasks that MERTI has undertaken have inarguable value. It brings into consciousness and focuses discussion on the relevance of cultural differences on the delivery of mental health care. The basic tenet of my presentation today is that in order for majority practitioners to provide beneficial services to minority clients, they must be aware of how race, ethnicity, and culture affects the individual client in his/her presentation for care and the practitioner in his/her delivery of care. This tenet is applicable for both clinicians and policy makers who are given the tasks of serving the mentally ill. Although this is an exciting and important topic, it is also vastly complex and carries with

it the risk of overgeneralization. It is critical that in discussing how one approaches a particular ethnic or racial minority, we remain mindful of intragroup heterogeneity. If you understand that no group is universally the same, then the development of stereotypes is inhibited and one can approach each individual as a unique being with multiple influences on his/her world view, beliefs, ideals and practices. Today I wish to convey why I believe this is an important topic and to articulate a way of understanding how ethnocultural differences affect both the client and the practitioner. I further hope to underscore that the practitioner's ability to comprehend and appreciate these differences has significant impact on the conduct of the treatment.

In Psychiatry a tradition of regarding the patient in his or her totality has evolved. The nature of the profession has become one of looking beyond what is obvious to find clarifying and unconscious connections. I think this framework for Psychiatry, total regard for the client, can serve as a guide for understanding or attempting to understand people whose experiences may be very different from your own. Understanding the experience, in and of itself, falls short of what one must accomplish. One must also accept and validate a person's differences and the impact that those differences may have had on the person's life. Over the course of the next forty or forty five minutes, I hope to provoke you and challenge you to examine how you conduct yourselves with ethnic minorities and how your actions may be influenced in conscious and unconscious ways.

George Engel (1977) introduced the concept of the "biopsychosocial model" in his search for a better medical model to explain physical illness. Since then his model has become a guide for evaluative processes in psychiatry. Engel's model implores one to look for multi-causal factors which may influence disease processes. The model is without a stratified focus and taken literally, it means that biological, psychological, and social factors play a role in disease. It instructs the evaluator to search in all of these realms when attempting to explain the disease process. In a practical sense we must remember that these factors are interactive and dynamic, and that the force of one factor may change over time and the level of influence on the disease process may shift. For example, a young man with schizophrenia who is stable on psychotropic medications and has lived independently for years may decompensate suddenly under the stress of an eviction notice or the threat of losing disability benefits or the termination of treatment with a long term clinician. He may very well decompensate if he fails to comply with his medications or even if he complies with it. The example shows that any set of factors may play a role in this man's illness and his health. It behooves those who treat him or who make policies that affect him to be aware that his biological disease may be influenced by his social condition or his interpersonal issues. It may be equally true that his social condition and interpersonal life may be influenced by his biological illness. It seems that we are more willing to accept these premises than we are to accept the impact that ethnocultural differences have on treatment and its outcomes. Perhaps the reluctance is a product of the intense and often unpleasant affects that are raised whenever issues of race and cultural difference emerge.

The presence of racially inherited disease and societal predispositions to illness as a result of poor sanitation or nutrition have fostered the belief that ethnicity and culture may influence health and illness. Within the past few decades attention has been turned to investigation of the question of whether there are ethnocultural determinants of mental illness. This has indeed been a difficult task because of the variegated expressions of mental illness and health in different cultures. lt is further complicated by the influence of the world view and language of the individual in the expressions of signs and symptoms of psychological distress. In the United States, this is further complicated by the multiplicity of ethnic and cultural groups which have come to make up a culturally pluralistic America. America has often been called a "melting pot" and this evokes images of persons from diverse backgrounds mingling to exchange important parts of their culture to produce a new and more exciting culture-an exchange of energies to forge a new creation. However, this is a most idealistic way of viewing the changes in America since cultural pluralism is a distinct feature of the American cultural landscape. Comas-Diaz and Jacobson (1988) have describe America as a "melange of ethnocultural diaspora in various stages of transition". Despite the prohibition of legal segregation, American communities remain highly segregated. Ethnocultural groups are scattered about, setting up neighborhoods defined by race and ethnicity. New York's Little ltaly or Chinatown illustrate this point, however, there are numerous other such examples. The development of communities along racial and ethnic dimensions means that significant interactions between ethnic groups will more likely take place in structured settings such as school or work and that social interactions in non-task oriented forums are less likely to occur. This lack of cross-cultural interactions in

a social context is likely to be a real factor in ethnoculturally different treatment dyads, where trust and intimacy of communication is absolutely necessary.

As American society as a whole has changed so has the profile of people seeking help from community mental health centers. In fact, nearly 20% of patients now seen at the nation's community health centers are African American and there is a positive rate of rise in all other ethnic group categories. Attitudes about mental health treatment have changed and so has the access to this treatment for those who previously could not afford it or who had no place at which to receive it. Much of this upsurge in the use of community mental health clinics is directly related to the passage of the "Mental Retardation Facilities and Community Mental Health Act of 1963" which authorized federal funds for the use by states in constructing community mental health centers. Since the passage of this act unprecedented numbers of mental health facilities have emerged and access of the poor and ethnic minorities to treatment have improved, but not without concern. Although access to ethnic minorities improved, evidence began to mount that minority clients received differential treatment allocation, biased diagnoses, and had high attrition rates. In 1978 a report from the Presidents Commission on Mental Health concluded that "networks of high quality mental health services must be developed if we are to respond to the changing circumstances and diverse racial and cultural backgrounds of our patients". It further stated that "despite the improvements in the nation's mental health systems, there are still millions who remain unserved, undeserved, or inappropriately served" and a large proportion of these millions are in minority group populations.

The rate of increase in the number of minority group members seeking and being treated In community mental health centers has not had a concomitant rate increase in the number of minority group member practitioners. The combination of an increased influx of help seeking minority clients and minimal changes in the number of minority practitioners indicate that the vast majority of minority group member clients will be treated in cross-cultural treatment arrangements. It is, therefore, inevitable that issues related to racial and ethnocultural differences will arise. There is also an increase in the number of foreign nationals who are training in Psychiatry and bring their own variegated cultural experiences with them. It is just as crucial for a client and therapist in a cross-cultural relationship to examine the impact of ethnocultural background of the client on symptom presentation, the nature of the therapeutic alliance, the expectations of treatment, and the responses to interventions as it is to examine hostile, erotic, or maternal transference in a treatment. It is equally important for the treater to be aware that his or her ethnocultural background may have significant impact on the way they perceive the clients concerns, how they interact with the client, and how they view what is important. Navarro (1980) contends that culture free service delivery does not exist. Elaine Pinderhughes (1990) further contends that "the programming of service delivery, the structuring of services for people, the engagement of patients and clients in the help-giving process, the degree to which people use services, the assessment and treatment of problems, and the evaluation of outcomes are all influenced by cultural values and traditions".

I hasten to add that ethnocultural similarity in the treatment dyad is fraught with its own kinds of difficulty including the therapeutic quagmire that develops when the client or the therapist assumes that each in the dyad understands the other implicitly because of "shared experiences". I once treated a young African American woman studying drama who often decried what she perceived as blatant racism in the awarding of parts in the school's plays. She would always state "you know what I mean" when referring to her perceived brushes with racism or in reporting some slight that a White person had made towards her. When I countered with a statement which indicated that I did not know what she meant and requested that she tell me what it was like for her, she seemed puzzled. She would say, "I know you know what I mean. You're a Black man. Certainly you ought to know". When I maintained my stance that I did not know what it was like for her, she proceeded to explain that she often wished she were White because it would solve all her problems, noting that a 'Black Juliet' was rarely seen. She felt guilty and ashamed for wishing this because in doing so she devalued her color and her culture. If I had simply shared her perception of the environment's racism we may never have had the opportunity to explore this critical issue. Research on the effect of ethnocultural similarity has not produced conclusive evidence that it correlates with successful outcome. There is growing evidence that the therapist's effectiveness tends to depend on his perceived credibility (Sue, 1981). This credibility depends on the therapists sensitivity to the client's distress and the client's experiences, including those related to his or her ethnocultural background (Griffith, M.S., 1977).

Many of the qualities that become an important part of the therapeutic process are not known to the patient and are subject to speculation and fantasy. In this unilateral relationship, at least with regard to information exchange, one of the most obvious characteristics of the therapist is his or her ethnocultural group. This becomes a key area of noticeable difference along with other physical characteristics. Some authors suggest that transferential reactions to racial and ethnocultural differences may be more intense than other transferential reactions. Pinderhughes (1973) suggests that persons from the same group understand each other primarily by introjection and ldentification, whereas they understand members of other groups primarily by mechanisms of projection. He further contends that the greater the difference between the therapist and patient, the more the therapist relies on projection. It is important to remember that the therapist may have strong countertransferential reactions to a client who is ethnoculturally different and may act upon these reactions if he or she does not develop appropriate ways of managing prejudice and racism, both projective processes. We are all influenced by the prevailing attitudes of our native cultures. Each of us is likely to project and generalize reality for other groups based upon the specific realities of our past experiences, including our familial and societal experiences. If we do not examine these possibilities or worst, never recognize them, then we will be incapable of assisting patients who are ethnoculturally different from ourselves. The processes by which differences acquire significance begins early in our lives and through the process of inculturation these differences take on meaning that is group specific. Invariably, the culture's dominant group (in terms of manifest power) will define those meanings and attribute values to them.

From the moment of birth, the human infant is thrust into a world of dichotomies. The infant emerges from a warm and soothing intrauterine environment and is confronted with a relatively cold and uncertain external world. This begins the processes of differentiation of the "self" from the "other". In normal human development the early symbiotic relationship to a care-giver is replaced by more self-sufficient activity which is a product of biological and psychological maturation. Although maturation leads to more independence there remains a fairly strong attachment to one's nascent group. From such group affiliation one learns one's values, world view, traditions, and is afforded some safety from belonging to that group. Comfort of belonging is found in familiar settings or with familiar people. Stranger anxiety can be very pronounced early in life and typically reaches its peak at around age 6-8 months. The characteristic anxiety and protest seen at that time diminishes and transforms into more mature versions, however there always remains an innate tendency to seek out and feel comfortable with the more familiar and to avoid and feel uncomfortable with that which is strange. This very basic reaction facilitates identification with one's own group and encourages alienation from those outside of the group. This lays the groundwork for the development of the "us" and "them" mentality which plays a prominent role in the developing the social structures that define culture and attributes meaning to difference.

The concept of culture is an experiential one. It is a complex construct which some have approached as an open system that is prone to evolutionary forces and hence is a form of adaptation for the group (Cohen, 1974). Culture then becomes the patterns of responses

that the group has adopted to meet its biological and psychosocial needs. It refers to the elements in the group such as values, norms, beliefs, attitudes, folkways, style of behavior, symbolic representations, and traditions that are linked together to form an integrated whole that functions to preserve the society (Leighton, 1982). Various characteristics, including race and ethnicity, contribute the maintenance of cultural groupings. America is a nation of immigrants who have contributed collectively to the development of an American culture, however the influence of an Anglo culture has remained predominant and serves as the reference point for all its ethnic groups who may be in varying stages of inculcation with American cultural ideals. The dominant culture in a society inevitably wishes those in minority groups to adopt the culture of the dominant group as the legitimate one. As a result of complex interactive processes people from different cultures perceive the world and each other very differently. The perceptions of what makes us different from others is as critical in forming our identities as is defining what makes us like others in our group. The categorization of ourselves into "us" and "them" is derived from these perceptions and becomes the basis for stereotyping and discrimination which in turn aids in the erection of social structures that circumscribe people's life changes and lifestyles and thus their cultural responses (Berger and Federico, 1982). The dominant group within a society uses biological, psychological, and cultural characteristics to differentiate others from itself, placing the differentiated group in a subordinate position, isolating them, and barring access to necessary resources. This re-enforces their dominance as the differentiating and categorizing group. These stratifications are institutionalized into social structures so that the expectations generated by the dominant group concerning the tasks and functions

appropriate for the subordinate group, affects the subordinate group's behavior and self-esteem, fostering a sense of relative powerlessness. The sense of powerlessness in turn fuels intra-group adhesiveness and the maintenance of cultural identity as defined by the dominant group (Pinderhughes, E., 1990). Erikson (1967), in his discussion of pseudospecies, comments that exploitative and suppressive systems are able to maintain their dominance in part because the exploited and suppressed unconsciously accept the evil image they are made to represent by those who are dominant. This is an important point because it captures the essence of the conflict that may emerge in cross-cultural relationships. Specifically, clients who are in subordinate cultural positions (in terms of manifest power) may find themselves in the awkward position of feeling vulnerable and eliciting help from someone who may hold socially sanctioned negative views of them. It may also be difficult for them because it will be expected that they present their concerns in the language and form that the dominant cultural group wishes; a proposition that may not be easy to realize. Social structures which are developed to maintain majority and minority cultural status help determine how people are viewed, how they view themselves, their access to resources, and their responses to their condition (Pinderhughes, E., 1990). It is crucial to remember that these processes are continuously operative and affect all of us in our relationships. Whether one is referring to gender, socioeconomic class, sexual orientation, or race there is an ongoing search within relationships to find commonality and difference and to attribute value and meaning to what is found.

Although there may be a myriad of differences which we may use to categorize

ourselves, very few may be as evident as one's racial or ethnic group. I will use the relationship between American Blacks and Whites as prototypic of the issues and difficulties which may arise in cross-cultural relationships and to illustrate those principles which must be operative in order to provide competent services to this group. I should make it clear that I am not advocating for all therapists or policy makers to become cultural anthropologists. Psychiatry is complex enough. It seems unnecessary for any of us to try to become proficient in another discipline. I do believe that some of the practices of cultural anthropologists, such as the unbiased examination of a group's behavioral styles, traditions, and world views are of some use to therapists. Competency does not imply that one knows completely the inner workings of a different culture. It implies that one dedicates themselves to trying to understand the variety of factors which contributes to a person's health and illness. It means that one examines one's own belief system to determine how and when projective processes, such as racism and prejudice, are at work, It means that one's racism must be owned and dealt with in appropriate and non-destructive ways. It is inconceivable to me that any useful therapeutic work can occur in a cross-cultural relationship if the issues of race and ethnicity remain unacknowledged and un-examined.

Racial or ethnic differences between the patient and therapist can have significant impact on the relationship. Although other ethnic groups may have profoundly noticeable differences with a White therapist, the differences between groups is brought into sharp focus when examining relationships between Blacks and Whites. Unlike other ethnic groups vis a vis Whites, there is almost universal depiction of Blacks and Whites as complementary

opposites. This is related, in part, to the use of skin color as a categorizing feature and the particular history of American Blacks as enslaved persons. The color white has connotations of the pure, good, and virtuous, whereas the color black represents evil, disaster, doom, and the dire and despicable. This imagery finds its way into everyday expressions such as "pure as the driven snow" or a "black-hearted man". The color white attributes positive characteristics whereas black represents the negative and unwanted. I have found only one commonly used expression for which black connotes something positive. The expression "in the black" is used to express fiscal soundness and surplus. This seems unusually ironic when one considers the socioeconomic plight of most of Black Americans. The "Black is Beautiful" campaigns of the 1970's was a direct assault by Black people on the attribution of pejorative meanings to the color black. As with other cultural beliefs and representations, these color connotations may be internalized and with them there may be primitive associated affects and reactions, from both the benefitting and maligned groups. The affect associated with these color based group and cultural identifications may be intense and may play an integral role in the effectiveness of the practitioner's attempts to provide care.

This relationship is further stressed by the brutal history of Blacks in this country in relation to Whites. There has long been inequity in the American system with regards to its Black citizens. The treatment of the American Black had stood as the sharpest of contradictions to the declaration of the founders of the American governmental system which declared that all men are created equal. For the expediency of a free labor force that

helped elevate America to world power status in a relatively brief time period, the American Black was treated with the utmost of contempt for the concept of equality for all. In fact, enslaved persons were considered chattel or fractions of a being. You may ask how this is relevant at this time? I respond by underscoring Nancy Boyd-Franklin's contention in her book, ***Black Families in Treatment: A Multisystems Approach***, that you can not underestimate the tone that the American slave experience has set for the treatment of Blacks as inferior. In ways large and small, this view of Blacks as inferior has been maintained. It is maintained by the persistent use of the color black as a symbol of badness and by the over-representation of Blacks in the print and audio-visual media as criminal, violent, deprived, and depraved. Pinderhughes (1966) states it thusly, "America has structured the white group toward a pattern of characteristics viewed as superior and the black group toward a pattern of characteristics viewed as inferior". The practitioner must open himself or herself up to introspection to understand how their culturally derived beliefs impact on their reactions to and regard of the culturally different person. If these feelings remain un-examined, then these internalized cultural systems can prompt the therapist to behave in unhelpful ways.

It is safe to say that discussions of race may evoke great anxiety, defensiveness, anger, shame and guilt. In part this comes about because any discussion about race inevitably raises the issue of racism and discrimination. Racism, a power system maintained by culturally defined social structures, evokes different responses from those who view themselves as victims of it and those who are benefactors of it. Unfortunately, victims of it may view themselves in the inferior and negative terms proscribed by the benefactors of

it. On the other hand, the benefactors of racism may feel guilt and remorse for enjoying the fruits of an exploitative system. Exposure of these feelings and vulnerabilities may incite denial that such a racist system exist, denial that differences matter (the defense of colorblindness), or lead to the belief that the problem is not racism and discrimination but the victim's preoccupation with their perceived victimization. The following passage from Shelby Steele's book (1990), ***The Content of Our Character, A New Vision of Race in America,*** is a stirring description of an evening ruined by an evocation of the American race issue.

> It was a warm, windless California evening, and the dying light that covers the redbrick patio is tinted pale orange by the day's smog. Eight of us, not close friends, sit in lawn chairs sipping chardonnay. A black engineer and I (we had never met before) integrate the group. A psychologist is also among us, and her presence encourages a surprising openness. But not until well after the lovely twilight dinner has been served, when the sky has turned to deep black and the drinks have long since changed to scotch, does the subject of race spring awkwardly upon us.
>
> Out of nowhere the engineer announces, with a coloring of accusation in his voice, that it bothers him to send his daughter to a school where she is one of only three black children. "I didn't realize my ambition would pull me into a world where my daughter would lose touch with her blackness," he says.
>
> Over the course of the evening we have talked about money, past and present addictions, child abuse, even politics. Intimacies have been revealed and fears named. But this subject, race, sinks us into one of those shaming silences where eye contact terrorizes. Our host looks for something in the bottom of his glass. Two women stare into the black sky as if to locate the Big Dipper and point it out to us. Finally, the psychologist seems to gather herself for the challenge, but it is too late. "Oh, I'm sure she'll be just fine," says our hostess, rising from her chair. When she excuses herself to get the coffee, the psychologist and two sky gazers offer to help.
>
> With four of us now gone, I am surprised to see the engineer still silently holding his ground. There is willfulness in his eyes, an inner pride. He knows he has said something awkward, but he is determined not to give a damm.

> His unwavering eyes intimidate even me. At last the host's head snaps erect. He has an idea. "To hell with coffee, "he says. "How about some of the smoothest brandy you've ever tasted?" An idea made exciting by the escape it offers. Gratefully, we follow him back into the house, quickly drink his brandy, and say our goodbyes.

The tension captured in this passage springs from historical wrongs and the persistence of limitations of access for ethnic minorities to society's resources. It is clear that some African Americans have prospered over the nearly thirty years since the passage of the Civil Rights Bill of 1964, however it is as equally apparent that most have not made major educational and economic gains. The economic discrepancy between those who have and those who have not, is an important reason for the maintenance of inter-group conflict which is preserved by the continuing uses of discriminatory practices. This creates a difficult set of conditions in which to establish the alliances and trust needed to deliver appropriate and helpful services in a cross-cultural therapeutic relationship.

The greatest challenge of psychotherapy is the development of a trusting relationship with another person such that a clearer understanding leads to better functioning and conflict resolution. The establishment of a trusting relationship is of paramount importance and is predicted upon the therapist's ability to be empathic, concerned, caring, and willing to listen to even the unspeakable. Success relies upon the therapist's ability to transmit a sense that the patient's total experiences will be listened to with interest and respected. No one will be humiliated or harmed. The openness necessary for such work may be in contrast to the adaptive styles that ethnic minorities may have developed to survive under the oppressive and unrelenting forces of racism and discrimination. There has often been a

failure by therapist to recognize the critical importance that society and social conditions play in individual development and mental health. Given the oppressive conditions under which most ethnic minorities and poor people live, it is not surprising that great deal of mental anguish exist. The traditional approaches which rely upon office based contacts in which one openly discusses one's feelings, thoughts, and concerns may not work with a patient whose lifetime conditioning has been in the opposite direction. The therapist who fails to adapt to this will lose the patient. Too often therapists will try to mold patients to fit into the model of treatment they provide, rather than accommodating a bit. Psychotherapy had been a predominantly white institution and to some degree it remains so. Individual psychotherapy, like other institutions, has been one from which Blacks were excluded, principally because they were "not good therapy candidates". This if course reflects the therapist's perception and that perception is influenced by the therapist's own projective processes.

I am often as impressed by those patients who turn out to be good therapy cases despite the negative press they received beforehand as I am with those patients described as good candidates who make little use of therapy. It is conceivable that if one modifies the way the patient is approached or modifies one's pre-conceived biases, ethnic minorities may be excellent candidates for therapy. I believe that the differential allocations of mental health services to minorities (more likely to receive group therapy rather than individual therapy), the high attrition rates, and greater misdiagnoses are attributable to failure to understand the ways in which ethnoculturally different people present their symptoms,

understand the concept of the therapy and its expectations, or view their role in the world. McGoldrick (1983) has written extensively and convincingly on the impact that ethnicity and race has on family systems and family therapy. She has found that race and ethnicity strongly determines what people see as a problem, how they present their problems, and what they expect from treatment. When working with any oppressed or traumatized group, it behooves the therapist to relinquish the notion that the individual is solely responsible for their misfortune. The therapist needs to acknowledge the reality that society can be wrong and that the individual may have suffered from societal structures which exclude, devalue, and abuse him. Attention to these processes require ongoing effort. As long as the society maintains a rigid system that excludes, debases, and denies opportunity to some of its citizens, the conflicts between the dominant and subordinate groups will continue and the therapist in a cross-cultural relationship will need to address its impact. If an ethnic minority patient sees the White therapist as part of the power structure and a benefactor of the social order, then a trusting relationship is unlikely to evolve. A therapist sensitive to this may modify his approach such that direct discussions of the patient's concerns about authority, power, discrimination, or racism can take place. The therapist must be prepared to experience the full force of affect that may be generated by discussion of race and ethnicity. The charged nature of this topic in America makes it one of the most difficult topics to debate. Discussion of race and ethnicity leads invariably to a focus on racism and discrimination. This is unavoidable given the nature of inter-group power dynamics and the effect that racism has on both the victim and the perpetrator. It is damaging to both.

Power is an inherent dynamic in all human relationships. In the treatment relationship the helper is given socially sanctioned power in relation to the help seeker. The help provider is seen as the authority who evaluates, diagnoses, and cures. The help provider is seen as the one who will determine what is wrong and what intervention is needed. The help seeker provides the necessary data and follows the recommendations. Power issues may be accentuated in cross-cultural relationships. In her masterfully written book, ***Understanding Race, Ethnicity, and Power***, Elaine Pinderhughes writes that the presumption of power "is present in the association of dominance, superiority, or denigration with ethnic identity and group status, in common perception of difference from others as "better than" or "less than", and in the dynamics of racism--itself a power system". She further suggests that the role of the therapist in these dyads is in empowerment of the patient such that one reduces the risks of demoralization, victimization, and the development of maladaptive actions to grant the self pseudo-power when placed in positions of relative powerlessness. If power issues are not managed well, the patient may avoid treatment, ignore recommendations, and participate in harmful struggles with the therapist. I recall a case discussion of a young African American man with paranoid schizophrenia who cycled in and out of the hospital because he promptly discontinued neuroleptic medications after each discharge. He took the medications while in the hospital without any resistance. His treaters were puzzled by his prompt discontinuations after discharge because he seemed to understand that the pills "controlled his thoughts". When a Black therapists explored this issue further with the patient, the patient acknowledged that he went along with the program while he was in the hospital "cause they keep you longer if you don't but

ain't no White people going to control what I think". When the role of the medication was placed in a different context, in this case appealing to one of the young man's strength, his desire to work, the results were different. The medication was explained as helping keep his "voices" in control so that he could concentrate fully on his job. By not recognizing the implied meaning of thought control in the context of Black-White relations, the White treaters evoked distrust of their actions by the Black patient and subsequent non-compliance.

In cross cultural dyads, the therapist must take care to manage their use of the socially sanctioned power. No doubt, power, like other human commodities can be abused. It may be used for the aggrandizement of the therapist who may wield their authority in response to their own inadequacies or it may be transferred to help the patient develop better and more adaptive coping strategies, to validate the role of societal influences on the individual, and to help the patient come to terms with the traumatic experiences of racism. Clinicians must find ways of examining their own behavior in cross-cultural encounters and to monitor the ways in which they manage the feelings, perceptions, and attitudes that are mobilized by their elevated cultural status. This process can only occur if the therapist approaches each encounter as a unique study into the origins of the physical, social, and cultural development and behavior of the patient. There must be adherence to the principle of attempting to understand the patient in his or her totality. The therapist must place considerable stock in trying to reconcile their notions of what is valued, what is to be believe, and what is pathological with an understanding of the unique experiences and

ethnocultural backgrounds of those being evaluated. The clinician must always explore whether what they see is dysfunctional or adaptive. The clinician must maintain a flexible and inquisitive attitude towards understanding the values, norms, beliefs, and experiences of those who are ethnoculturally dissimilar while at the same time remaining cognizant of how to limit any negative impact that his or her own beliefs, value judgements, and biases may have on those relationships. The clinician must develop cultural sensitivity which demonstrates acceptance and tolerance of difference and an ability to appreciate the variability that may occur within particular cultural groups. The most problematic consequences of failing to keep this perspective are the over-attribution or under -attribution of pathology to some cultural responses.

CONCLUSION

The danger of this presentation is that it will heighten pessimism about the ways in which one can approach issues of race and ethnicity or that it may promote an overestimation of the influence of society on the mental state of ethnic minorities. Clearly, ethnic minorities can suffer from significant mental distress and illness. However, there must be ongoing attempts to understand how racism and discrimination can affect adversely mental health, intergroup relations, and the therapeutic relationship. Sensitivity to such issues may foster the development of a trusting relationship and lead to beneficial and successful treatment outcomes. The ability to establish trusting relationships is of utmost importance in the efficient delivery of services to patients. The individual therapist and the

institution with which they are affiliated must be diligent in their efforts to increase awareness of the influence of discrimination and racism in cross-cultural relationships. Acknowledging and understanding that we are more prone to use projective mechanisms to understand those outside our own group and that these processes begin early in one's individual development may help us begin to manage and modify our reactions and approaches to those who are ethnoculturally different. The traditional therapeutic stance which expects the individual to open up to their therapist and to share thoughts, feelings, and vulnerabilities must be modified with ethnic minorities because keeping things in may have been a conditioned adaptive response which has permitted survival. Cultural competency embodies all that allows the therapist to transcend his or her own projections such that he or she can listen to their patient's life experiences with positive regard and manifest interest. A therapist from the dominant cultural group needs to understand that a patient from a subordinate cultural group may resist treatment when the therapist is inflexible or uses power in maladaptive ways. It is crucial for therapists, regardless of the cultural mix, to allow the patient to become a partner in the treatment and to continuously examine how they react to, understand, and conceptualize those things which are important to the patient, and how the patient adapts to them.

I hope this has been helpful in defining the importance of the tasks MERTI has undertaken. I have no doubt that these efforts will improve the quality of care that minority patients receive and the sensitivity of those who treat and make policy that affects health care delivery.

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PUBLIC PSYCHIATRY AND ETHNIC/RACIAL MINORITIES

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BAYLOR COLLEGE OF MEDICINE

HOUSTON, TEXAS

"Good morning" I am very happy to be here with you as the keynote speaker for MERTI's New York Forum on professional training needs of clinical staff in the public mental health service system. I am particularly pleased with the confidence displayed in me by Drs. Phyllis Harrison-Ross, Joseph Suarez and Ivan Quervalu and the opportunity to share my experiences with you.

In preparing and organizing my thoughts about the presentation I thought that the most poignant and relevant remarks I could offer you in relation to the interests and objectives of the Forum should encompass some of my experiences while working in the New York Mental Health system. I worked within this system in New York City from 1968

to 1981. During this period, I was the Director of the Day Hospital at Lincoln Hospital CMHC (1968 to 1969), Director of the Lincoln Hospital CMHC (1969 to 1977), Assistant Dean for Clinical Affairs at Albert Einstein College of Medicine for Lincoln Hospital (1977 to 1979), and Director of Bronx Psychiatric Center (1979 to 1981). In 1981, I moved to Houston to become the Chief of Psychiatry at the Harris County Hospital (Ben Taub General Hospital). As you can see from the cited positions, I have spent my whole professional career, 22 years to date, working in the public mental health system.

The core message that I want to convey, today, has to do with the importance of understanding persons with different cultural backgrounds, different ethnic origins, and different mental health needs. These differences offer us, as mental health practitioners, a major challenge in assessing, diagnosing and treating, ethnically and culturally diverse, patient populations. Further, socio-economic problems and deprivations also compound these challenges. In this context, let me now focus on specific issues for consideration and discussion.

RACIAL BARRIERS (RACISM)

Despite the progress achieved recently in this respect, particularly in New York State, much still needs to be done. Let me illustrate what I mean. In 1975, the admission rates for Blacks in State and County mental hospitals in the USA was 367.5 per 100,000 population in comparison to only 159.7 for Whites; the percentages of admissions to State

and County mental hospitals via police, court or correction agency referrals was 34.3 for Blacks and only 27.2 for Whites; the percentage of admissions to private mental hospitals in the USA was 40.6 per 100,000 population for Blacks, 34.4 per 100,000 population for Hispanic-Americans but 64.4 per 100,000 for Whites. The percentage of admissions with insurance coverage in State and County mental hospitals in the USA was 13% for Whites but only 3.3% for Black-Americans and 5.5% for Hispanic-Americans; the median lengths of stay in State and County mental hospitals was 24 days for Whites and 33 for Blacks. The distribution of outpatient psychiatric services in accordance to educational status shows that 14.9 percent of Whites have some college education while only 8 percent of Blacks and 8.2 percent of Hispanic do so. Finally, only 30.4% of all White admissions to State and County mental hospitals were considered schizophrenics while 36.3% of Hispanic-Americans and 44.9% of Black-Americans were diagnosed as such. For depression, 14.1% of all White admissions had a diagnosis of depression while only 7.7% of the Hispanics did so.[1] I do not want to beleaguer you with too many numbers, but these cited, official statistics more than prove the point that I am trying to make. It is also important to refer to official figures in order to avoid the assumption of resorting to rhetoric. While these figures relate to racial barriers (racism) and their impact on patient care, the same holds true for program (development) and staffing (patterns).

In 1985 Dr. Andrea Delgado and I published a paper in "Administration in Mental Health."[2] In this article we extensively discussed the impact of negative attitudes on the part of subordinates and supervisors vis-a-vis minority mental health executives.

Incidentally, this article was prepared while she was working for the Office of Mental Health in New York State, right here on the campus of Manhattan Psychiatric Center where this Forum is being held. Along these same lines, while on the professional and academic staff at the Albert Einstein College of Medicine, I had to work much harder than my fellow White colleagues in order to be recognized as an equal. At Baylor College of Medicine, in Houston, Texas, I found this situation to be even worse. I hope that my comments in this respect will not deter you from moving forward professionally, but will help prepare you to face the myriad of constraints and frustrations which lie ahead of you, in regard to the insidious forms of racism, and the manner in which these are manifested.

CULTURAL BARRIERS

The second point which I would like to focus on in this presentation has to do with cultural misunderstandings and barriers, and their resultant consequences for patient care. It is in this area that I have spent the largest amount of my professional and academic career. These cultural barriers lead to profound difficulties in both diagnosis and treatment. For instance, most Hispanic patients tend to express depressive symptomatology in terms of body aches, feelings of weakness, exhaustion and fatigue. Similarly, anxiety, in and of itself, may not be recognized by Hispanic patients, since it is manifested in terms of heart palpitations, dizziness and fainting. Also anger tends to be manifested as nervousness and/or malaise. Perceived Hispanic norms such as: present time orientation, lack of attempt to modify the effects of their environments, and the high endorsement of idealized

humanistic values may lead to major problems in therapeutic relationships and expectations, unless therapists are well aware of these cultural factors.[3] Another important cultural issue among Hispanics relate to religion. Most Hispanics are raised as Catholics and this fact is accepted without question by therapist who are unfamiliar with the nuances of Hispanic culture. However, many Hispanics, particularly from the Caribbean basin or from low socio-economic backgrounds, do practice a second religion be it Spiritism, Santeria or Brujeria in varying combinations and concomitantly with their Catholicism. For these Hispanics, mental illness is primarily caused by supernatural forces, and if one tries to discuss their mental illness from the point of view of psychological conflicts, biological imbalances or medical conditions, we will not only confuse them, but such a discourse will also lead to rejection of our scientific notions, inability to develop a most needed therapeutic alliance, and most importantly, non-compliance. What therapeutic purpose does it serve to appropriately assess and diagnose a patient if the prescribed treatment and management of care is not congruent with the cultural values and belief system of the patient. This is the challenge. Cultural determinants specify the manner in which individuals perceive and interact within the therapeutic environment, adhere to treatment and management regimens, as well as impact the behavioral manifestations and extent of psychopathology. Folk healers, however, have no cultural barriers when dealing with these patient's symptomatology. They come from the same cultures that their clients/patients come from, they live within the same barrio geographical boundaries, and they experience the same types of problems. Therefore, they are in a much better position, than we professionals are, in securing their patients/clients identification, in assuring compliance, and in getting services' satisfaction. For these reasons

I have always advocated for a close cooperation between mental health practitioners and folk healers. Certainly, I was able to do so while working in the South Bronx's section of New York City, at the Lincoln Hospital CMHC.[4] A good example of what I am trying to convey to you is the Puerto Rican Syndrome (Ataque de Nervios) which was first described in the medical literature by Dr. Roberto Fernandez-Marina in 1961.[5] This syndrome expresses itself with a series of hyperkinetic manifestations and seizure-like behavior. The unfamiliar therapist may confuse this syndrome with a serious medical problem such as epilepsy, and thus subject patients to a series of unnecessary and expensive tests. Another example has been provided by Dr. Ruben Rumbaut. Dr. Rumbaut has reported in the medical literature the symptoms of mild paranoia and euphoria seen in Cubans when they first arrive in the United States.[6] These symptoms, however, are not to be confused with paranoid syndromes and bipolar illness. They are only transient and followed by anxiety and depression when realization of the painful limitations and long struggles that lie ahead are recognized on a pre-conscious or conscious level. In addition, our traditional training and didactic experience, stresses the negative nature of psychiatric symptoms, and something to get rid of. Symptom eradication is, in accordance with our professional beliefs, the first step towards cure. In most instances, symptoms are eradicated with potent neuroleptic and antidepressant medications. All of these drugs also have major side effects and risks. However, symptoms which are culturally determined, and thus part of the norm for a given ethnic group, should be left untouched rather than submitting patients to a variety of risky somatic approaches. Even certain hallucinatory and delusional experiences can fall within the accepted cultural values and belief systems, ie., an attempt to speak with a dead person,

in an otherwise normal context, by a Hispanic person who has recently lost a close relative.

Therapeutic goals can also create culturally related difficulties in treatment. For instance, Anglo trained professionals tend to value the pursuit of "independence" on the part of their patients, as well as the pursuit of happiness in life. Hispanics, however, tend to value interdependent relationships, as well as seeing life as an endurance process. Along the same lines, Anglos, in general, equate wealth with success in life, while Hispanics, on the other hand, perceive success with securing "love", "dignity" and "respect" (Amor, Dignidad y Carino). There are a myriad of ways in which culture plays a major role in the mental health care of Hispanic patients. ie., non-verbal communication, dress codes, gifts to professionals, space orientation, time orientation, physical contacts with patients, and the like.[7]

Black Americans, Asian-Americans, Native Americans and other ethnic minority groups residing in the United States also experience cultural and racial barriers to quality mental health care. As a matter of fact, some of the examples I cited in regard to Hispanic-American patients also have application to many of these different ethnic subgroups. Some examples should bring confirmation of this assumption. For instance, Black schizophrenics tend to show more anger, impulsively, and dysphoric behavior than White schizophrenics. However, this culturally related manifestation does not imply that schizophrenia among Blacks has a poor prognosis or is a more serious illness. Also Black schizophrenics from rural areas in the United States tend to exhibit greater lability of affect, hypermotor activity,

confusion and visual hallucinatory experiences. Black urban schizophrenics, in comparison, tend to exhibit more autistic and passive behavior.[8] However, among White schizophrenics, there are not differences in symptomatology between rural and urban White populations. Being unfamiliar with these differences in symptom manifestation among schizophrenic Blacks, might lead to diagnostic and therapeutic errors. Dr. Frank Acosta has reported that Black patients often terminate therapy prematurely not because of a lack of motivation as has been generally perceived and quoted in literature, but because of negative attitudes toward culturally insensitive White therapists.[9] I hope that these observations and discussion of cultural barriers will encourage you to address the issue as a top priority during your professional development and career.

LANGUAGE BARRIERS

Mental health, more than any other health care related field, is dependent on the ability to communicate and be understood. Nevertheless, not enough attention has, thus far, been given to this issue. Three major questions need to be addressed in this context. They are:

1. Does the language used during the psychiatric assessment of a bilingual patient have any impact in the diagnosis, and consequently in the treatment recommended?
2. Does reported symptomatology elicited from a bilingual patient exhibit different degrees of psychopathology depending on the language used during

the assessment and treatment process?

3. What is the role and effectiveness of interpreters in mental health care?

I will attempt to focus on these three basic questions in this section of my presentation. By far, most mental health practitioners in the United States are of Anglo-Saxon extraction and are monolingual, speaking only English. In comparison, the Hispanic-American population of the United States is the fastest growing. J. Del Castillo was the first professional who focused on the issue of the language barrier in the delivery of appropriate mental health service.[10] He suggests that using a non-native language forces patients to be so concerned with his/her communication efforts that the natural expression of emotions is inhibited. Moreover, it was Dr. Luis Marcos in the early 1970's who methodically, and with the use of standardize interviews tackled this issue head on.[11] Based on his studies, Marcos concluded that Hispanic patients exhibit significantly greater degrees of psychopathology, particularly insofar as tension, anxiety, emotional withdrawal, depressed mood, and somatic complaints when interviewed and/or assessed in a non-native language (English). Furthermore, he demonstrated that this situation culminated in more serious diagnoses when the interviews were conducted in English. Definitively, speaking in a second language causes deterioration in cognitive function with all of its negative clinical implications. Needless-to-say, diagnostic errors undoubtedly lead to inappropriate treatment measures, alternations of prognostic values, and complications throughout the treatment process. Many of the patients used for this study tended to speak slower and have longer periods of silence, thus exhibiting characteristics frequently associated with depressive

symptomatology, which in fact were due to cognitive stresses.

Another clinical problem related to language, concerns fully bilingual patients who switch to the non-native language when discussing emotionally charged issues, as resistance to acknowledging and dealing with their real emotions. This problem is particularly important with second and third generation Hispanic-Americans who have mastered the use of the native, as well as the non-native language (English). These language barriers also have a negative impact on the development of the highly relevant "therapeutic alliance"- the treatment mechanism which mediates the therapeutic process from its inception through the establishment of the patient-therapist relationship, as well as the evolution of the support or insightful phase and negotiation of the termination of the treatment or closure phase. Perhaps this is one of the factors why Hispanic-Americans tend to heavily underutilize mental health services in this country, with all of the negative connotations that this produces. Hispanic patients tend to use non-verbal means of communications extensively thus further compounding this problem. Particularly, when the Anglo society heavily values verbal expression. I have seen, again and again, both in New York and Houston, White professionals recommending only somatic therapies just because the Hispanic patient in question used limited verbal means of communications. This, in my opinion, not only constitutes poor quality of care on the part of these professionals, but negligence as well. The use of small talk (platica) with Hispanic patients tends to increase confidence, informality, and relaxation, and consequently facilitates verbal communication. Small talk (platica) will also help develop and/or boost the "therapeutic alliance". The utilization of

small talk (platica) on the part of Hispanic-American patients might however, be erroneously perceived by non-Hispanic mental health professionals as evasiveness or unwillingness to confront real problems or issues. On the contrary, allowing a period of small talk (platica) can facilitate the establishment of good rapport, and subsequently induce a greater level of self-disclosure during the session.[12] Eye-to-eye contact is of importance to Anglo professionals when interviewing a patient. Furthermore, lack of eye-to-eye contact might be interpreted as a sign of schizophrenia. However, some Hispanics, particularly those from low socio-economic backgrounds, tend not to establish eye contact with authority figures when talking to them. Professionals for Hispanics denote authority with its implied structural power relationship in which the culturally charged concept of respect (respeto) demands adherence to a prescribed behavior pattern where reverence of and subservience to the authority figure is expected, as well as acceptance of his/her advice, council or recommendations as dictums not to be questioned. For the inexperienced non-Hispanic professional this situation could lead to erroneous assumptions, misdiagnosis and poor treatment. Language barriers also play a major role in psychological testing where the ability to understand the nature of the task at hand and answer examiners question is of utmost importance.[13]

Let me now focus on current findings concerning the utilization of interpreters as a way of resolving language barriers. Dr. Luis Marcos has also dealt extensively with this issue, and has a number of publications on the subject.[14] A review of his work leads to the following conclusions:

- Patients emotional suffering and despair is underestimated
- Interpreters' attitudes towards patients and clinicians lead to problems
- Interpreters act out for being delegated too much responsibility
- Volunteer interpreters generally get angry when requested to translate when they are too busy
- Interpreters tend to over identify with patients
- The use of interpreters during the interview process creates a great deal of tension for all involved
- Interpreters become embarrassed when having to translate sexual and suicidal questions
- Interpreters and patients may become concerned with lack of confidentiality
- Interpreters tend to distort, or are not capable of translating clinical constructs related to: thinking process, emotional withdrawal and blunted affect
- Ambivalence on the part of the patient is difficult to translate
- Para-linguistics, and vocal cues can't be translated
- Cultural behavior is difficult to be translated
- If the interpreter is a non-professional, his/her lack of clinical knowledge could lead to problems
- Patients' relatives/friends are not objective interpreters. They tend to either minimize or exaggerate the patients' pathology

- Certain patients (paranoids and overanxious) can't tolerate the presence of an interpreter
- Certain patients (dependents, depressed, histrionics) react too well to the use of interpreters due to the excessive attention paid to them
- Use of interpreters lead to gaps such as: omissions, additions, substitutions, condensations, etc. All related to bilingual incompetency or lack of interpretation skills.

Example:

Clinician: How is your mood? Interpreter: How are you feeling?

Patient: I have no pain.

Interpreter: He is doing fine.

Clinician: Mood is fine.

Example:

Clinician: Are you contemplating suicide?

Interpreter: Do you want to die?

Patient: No.

Interpreter: Denies suicidal ideation.

Clinician: Good, no suicidal risk.

Interpreters like to summarize patients' answers or clinicians' questions. Interpreters

prefer to normalize patients answers. Nobody likes to see anyone being mentally ill. Loosening of associations can't be translated (i.e. blocking). Interpreters tend to help make sense of the patients' answers.

Example:

Clinician: Do you have worries?

Interpreters: Are you afraid?

Patient: No, God is with me, so they can't get me.

Interpreter: He is not afraid.

Clinician: Patient has no worries.

Affect depth can't be translated. Interpreters translate what was said, not how it was said.

Results: Clinicians become misinformed, misinterpreted, misrepresented, and thus misdiagnoses are made.

Solutions: To use only skillful interpreters, to have bilingual clinicians, interpreters and clinicians should meet before the interview in order to clarify goals and strategies. Clinicians must be well aware of the problems confronted when using interpreters in order to minimize these problems as much as possible.

Hopefully this discussion about language barriers in the mental health field will help you to understand and value the need for fully bilingual, and culturally sensitive mental health professionals.

SOCIO-ECONOMIC BARRIERS

In any discussion where issues related to minority mentally ill patients are addressed, one must also focus on socio-economic conditions. A particular patient may have certain needs insofar as their mental health and their mental illness are concerned. However, the demands for services, access to appropriate mental health facilities, and the available supply of these programs are all directly related to socio-economic status. Our homeless psychiatric population, the increased number of psychiatric patients ending up in the criminal justice system, the level of staffing patterns in our state hospital system, the current undersupply of psychiatrists, child psychiatrists, psychiatric nurses social workers, and other relevant professional disciplines, the insufficient insurance coverage for mental health services, the constant increase in the number of uninsured persons in the United States all depict the important role that socio-economic factors play in the mental health field. Needless-to-say, minority populations are the most affected by these socio-economic barriers, as a result of their being in the lower part of the socio-economic scale of this Country.

Educational factors are equally linked to socio-economic status, and also play a major role in this regard. The focus on specific issues might help to understand the interplay

between socio-economic conditions and availability of quality care in the mental health field. According to the 1980 U. S. Census there were approximately 26.5 million Black Americans in the United States or 11.7% of the total population. However, 3.1% of the total number of physicians were Black. Similarly, there were approximately 14.5% million Hispanics, or 6.5% of the total population. However, only 4.3% of the physicians are Hispanics. The educational debt burden per medical student was $19,697 in 1981, increasing to $42,374 in 1989. In 1981, 10.3% of all U.S.A. physicians were practicing in large city suburbs. In 1989, these increased to 17.4%. In 1981, 1.1% of all physicians were practicing in rural America, but by 1989 these decreased to 0.8%. In 1972-73 there were 18,395 foreign medical graduates filling residency positions in the USA, while in 1989-90 there were only 12,433. In 1974-75 the minority medical student enrollment in the first year of medical school was 7.5%, while in 1989-90 these decreased to 7.3%. Mexican-Americans represented 1.5% of the first year enrollment in 1974-75 and increased slightly to 1.8% in 1989-90. Puerto Ricans represented 0.5% of first year enrollments in 1974-75 and increased to 0.8% in 1989-90.[15] I have focused on these figures of minority physicians since I am more familiar with this data. However, I would suspect that this pattern is also present among other traditional mental health disciplines. The implications of these figures insofar as minority mental health is concerned is devastating to say the least.

Let me now turn your attention to the phenomenon of "suicide". It is already an established fact that an increase in the level of unemployment produces a proportional increase in the rate of suicide. In 1980, the annual rate of suicide per 100,000 population

in the USA was 12.5 for Whites, 6.8 for Black Americans 9.0 for Hispanic-Americans, 8.0 for Chinese-Americans and 7.8 for Japanese-Americans. I do not have suicide rates for Native Americans which are reported to be abnormally high, and a chronic problem whose dynamics reflects more than a reaction to unemployment on the reservation, and includes the vestiges of governmental policy with all of its negative ramifications towards a vanquished enemy. The male ratios were higher for all these ethnic groups with the exception of Chinese-Americans (7.9 vs. 8.0); Whites: 18.9 vs 5.7, Blacks: 11.1 vs 2.4 and Hispanics: 17.8 vs 4.0 However, an analysis of the suicide rates in the East Harlem section of New York City showed that the annual suicide rate for Whites was 31.5 for males and 32.5 for females; for Blacks 29.6 for males and 10.7 for females and for Puerto Ricans 44.5 for males and 10.7 for females. These East Harlem rates surpass by far the national averages for both males and females.[16] Undoubtedly, the level of poverty, and unemployment, the low index of education, and other related socio-economic indices, which are prevalent in the East Harlem urban slum, clearly demonstrates the relationship that prevails between socio-economic conditions and suicide.

In general, clinicians, pay more attention to clinical factors, and less to the relationship between socio-economic factors and the accessibility and availability of mental health care. However, I submit to you that socio-economic barriers are the most important among the types of barriers facing the mentally ill patient in his/her quest for services. Hopefully, I have been able to help you understand this relationship.

CONCLUSION

The scope of my presentation and time limitations have not permitted me to focus on a series of issues which are, in my opinion, quite relevant in the field of public mental health. They are as follows:

- Utilization of primary prevention models
- The care of the homeless mentally ill
- The psychiatric care of the AIDS patient
- Models of team approaches in mental health care
- The psychosocial rehabilitation of the chronic mentally ill patient
- The care of the dually diagnosed patient
- The care of the forensic patient
- The role of primary and secondary consumers in mental health care

I hope you will all give serious considerations to these issues in your clinical practice.

In summary, I have attempted to focus attention, discuss, and offer current perspectives in regard to some of the most significant barriers to the care of the minority mentally ill patient. In so doing, I hope that I have offered you a new and relevant outlook in dealing with them. In addition, I also hope my remarks have stimulated you to further investigate the parameters of these barriers, develop and define new solutions for overcoming them, and most importantly, to conduct appropriate and innovative research in

this area. It is through the development of new knowledge that we can expect to help improve the delivery of mental health services to the ethnic/racial mentally ill, and eventually restore them to the community as productive citizens.

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THE SIGNIFICANCE OF ETHNIC, RACIAL, AND CULTURAL DIVERSITIES IN PSYCHIATRIC TREATMENT

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Ethnic, racial, and cultural diversities while constituting hallmarks of the American democratic society, often require individual and group social adaptations; and these are complex, poorly understood, and operate on both conscious and unconscious levels. In no other area of human interaction as in psychiatric treatment is cultural diversity as seminal to the initiation, progress, and outcome of the process; yet in no area are the issues as subjective and poorly defined.

This presentation will examine parameters related to the topic and propose a schema for their further investigation, integration, and application to clinical practice.

TOPICS

A. Literature review

B. Child development

C. Education and training

D. Supervision

E. Transference and countertransference

F. Case examples

G. Proposals

H. Research

I. Bibliography

A. LITERATURE REVIEW:

Judith G. Rabkin and Elmer L. Struening in ***"Ethnicity, Social Class, and Mental Illness"*** begin their project by defining ethnicity as "a shared history that plays a major role in shaping the culture of a group of people---their values, attitudes, and life styles". In an analysis of five ethnic and racial groups in New York City (Jews, Blacks, Puerto Ricans, Italians, and Irish), they define correlations between ethnicity, social class, and mental illness. Knowledge of the ethnic composition of certain geographic areas (holding social class constant) allowed the investigators to predict with a 37% accuracy rate the incidence of psychiatric hospitalization.

With Blacks, the greater prevalence of major psychiatric hospitalization and higher rates of rehospitalization were attributable to:

1. The less favorable treatment accorded Blacks in their contact with the

mental health system.

2. Lengthier periods of hospitalization relating in part to the referral having been frequently initiated by public authorities, police, or courts.

3. Pre-existing social conditions that contribute to the need for professional help.

Diagnosed mental illness was found more often among Puerto Ricans in New York City than among then the rest of the population and related to:

1. Factors of migration
2. Social class and community status
3. Childbearing practices and role definitions
4. Advocacy of a spiritualistic conception of mental illness.

With the Jewish population both demographic and cultural characteristics were associated with lower rates of psychiatric hospitalization. "Greater material assets and interest in Psychiatry as problem-solving method seem related to earlier and probably better out-patient treatment. In many instances, this forestalls the need for the more extreme step of hospitalization".

Italians as the second largest White ethnic group in New York City evidenced strong local and family bonds; the latter frequently encompassing several generations. In addition:

1. Rates of psychiatric hospitalization were low (but increasing over the past 65 years)
2. Mental illness was related to a lack of self-control and conceptualized in moral language and dealt with by church and family.

The Irish population of New York City represent the ethnic group that is most evenly distributed spanning the area from the Bowery to Wall Street, and showed the following characteristics:

1. Compared to other first and second generation Americans, the Irish have higher rates of diagnosed mental illness and higher prevalence rates of alcoholism.

I felt that it would be helpful to present this research in order to underscore the fact that ethnic, racial, and cultural factors are directly related to mental illness, psychiatric hospitalization and outcome of hospital care.

Let me shift from epidemiology to psychotherapy in terms of relevant literature. Schachter and Butts in "***Transference and Countertransference in Interracial Analyses***"

published in 1968 describe analyses in which analyst and therapist differed racially. They conclude that:

1. Racial differences may have little or no effect on the course of the analysis.
2. Racial differences may have a catalytic effect upon the analytic process, and lead to a more rapid unfolding of core problems.
3. Stereotypes of race and color occasionally induce both analyst and patient to delay the analytic process, either by obscuring reality or by overestimating its importance.
4. Subculturally acceptable pathology or acting out may evoke over-reactions in the analyst, while material fitting racial stereotypes may be ignored.
5. Countertransference may coincide with stereotypes and delay the analytic process.

One of the authors of the original paper reviewed the area of interracial therapy and cited certain clinical insights that have surfaced in the past twenty years; one of which is the increasingly positive attitude with which Whites approach therapy with Blacks; leading to the negotiation of a healthy therapeutic engagement. In part this tendency relates to the socio-cultural-media impact of altered views of Blacks.

The paper by Schachter and Butts was preceded by other noteworthy works by Bernard,

Kardiner, Kennedy, Oberndorf, Pinderhughes, and others.

B. CHILD DEVELOPMENT:

Observations on the responses of children to cultural diversion and racial differences lead one to conclude that children's responses to cultural diversity are learned; further that those responses represent attitudes present in the society at large. Research confirms that the African-American child's concept of self ethnically and racially is established sometime between the ages of 3 and 5. Drs. Kenneth and Mamie Clark in a paper entitled "***The Development of consciousness of self and emergence of racial identification in Negro preschool children***" come to that conclusion. In addition, the Clarks review the relevant literature in the area. Piaget and Baldwin referred to a three stage development of "personal consciousness" maintaining that the child discovers himself through a progressive comparison of his own body with other people's bodies. The three stages were - projective, subjective, and finally ejective stage of personality development. The final "ejective" stage is one in which the child is aware that other people's bodies have similar experiences to his own.

Lewin in his book, "***Dynamic Theory of Personality***" focused on the formation of the concept of property as a feature of the development of self-consciousness. G. W. Allport felt that self consciousness develops only after the age of four or five. Moreno ("Who shall Survive"-1934) used a sociometric test wherein children chose from pictures of various racial

groups the boy or girl whom they would like to have sit on either side of them. He found that "gradually from the first grade on the group develops a more differentiated organization". From about the fifth grade...a greater number of Italian children begin to choose Italian neighbors...a larger number of White children reject colored children...It indicates the beginnings of a racial cleavage.

Once the concept of self on racial, ethnic, and cultural grounds is established in children, there then sets in a dynamic sequence in which ones group is regarded as the favored group or group with most esteem; whereas other groups are looked upon with disfavor. (see Pinderhughes-Group Related Paranoia) The development of racial, ethnic self concepts in children and the appreciation of racial, ethnic, cultural differences leads into the complex issue as to how those differences are reconciled. Dr. Charles Pinderhughes has been of invaluable help to us in understanding how individuals come to aggrandize their group and denigrate the groups of others "***Understanding Black Power Processes and Proposals***"
"Persons perceived as similar to one's kind are identified with, are valued highly, are trusted, are taken in...like food...are thought of as right and pure and are associated with the "higher things in life"...with the head...and with the mind."

Persons seen as different are not taken in...are not seen as food...are seen as objects to keep out with vigilant defensiveness and suspicion. They are perceived as wrong, or inadequate, or sinister, and are rejected. If their appearance, culture, and behavior shows characteristics on which a low value is placed, they are associated further with low things,

with the bottom...and with the buttocks and genitals. Between persons whoa re not members of the same group, understanding tends to take place by projection, rather than by introjection and identification."

C. EDUCATION AND TRAINING:

Cultural, ethnic, and racial diversities require that professional programs in the behavioral sciences include training that will equip trainees to deal with diversity. In addition to epidemiological studies, the following topics, areas of concentration, and considerations should be incorporated into behavioral science training programs:

1. A course in comparative ethology
2. A course in racism
3. A course in African-American history
4. A course integrating literature and psychoanalysis

In addition, every effort should be made to attain ethnic, racial, gender and cultural diversity among staff. Every effort should be made to attain ethnic, racial, gender and cultural diversity among the patient population.

Programs should aim for the acquisition of a diverse supervisory staff which can provide trainees with the kind of sensitive supervisory experience needed when working with a diverse clientele.

CASE EXAMPLE # 1

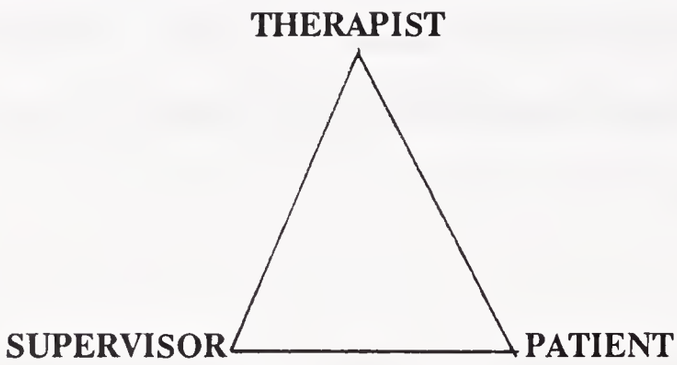
A White, southern born psychiatric resident treating a Black man in his mid-twenties for a variety of obsessional symptoms had his initial meeting with me in group supervision in September of the year. We discussed his case and jointly speculated as to the techniques that were needed and I made several recommendations. He had a dream on the night of our initial supervisory session which he reported to me nine months later when supervision was about to end for the year.

> **DREAM: I am a wealthy southern industrialist and have just arrived at Pennsylvania station. I have several bags and look around for a porter to take them to a cab. I spot you (the supervisor) and motion for you to come over. You take the bags but instead of going toward the cab, you run in the other direction. As I realize that you're stealing my bags I become furious and scream "you can't trust niggers".**

The disparity between the supervisor's helpful stance and the supervisee's denigration of him in his dream poses several questions: the supervisee's need to distort a helping situation into a rage-filled one focussed on the race of the supervisor raises characterological conflicts for the supervisee that interfered with his treatment of the patient and his ability to utilize supervision in a productive manner; the supervisee's difficulty in discussing the

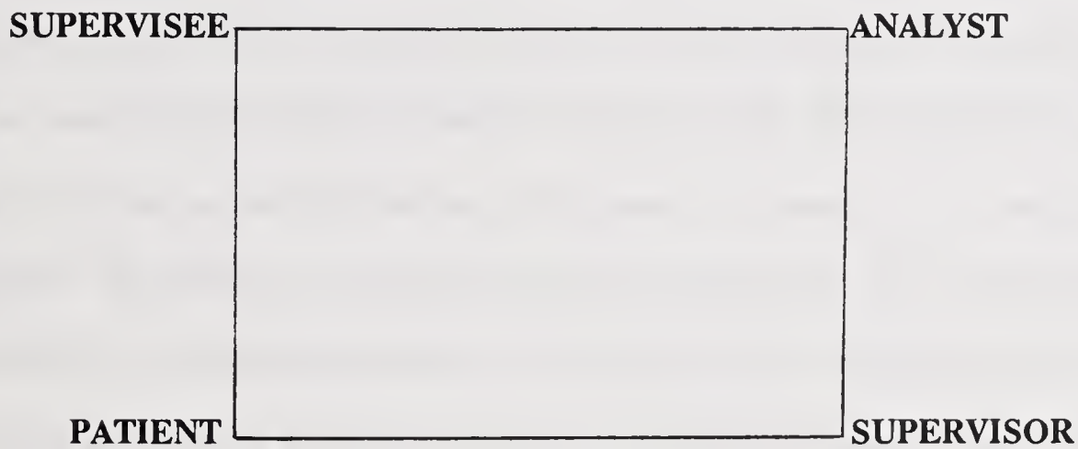
D. SUPERVISION:

A former supervisor of mine, the late Dr. H. Lee Hall conceptualized the supervisory process as a triangular one in which patient, therapist, and supervisor each are located at an apex of the triangle.



Thus while the therapist-patient dyad is primary, the therapist-supervisor dyad is important and the supervisor-patient dyad is also significant. The supervisor has both a direct and indirect effect upon the treatment; further no description of the treatment process is complete without reference to the impact of supervision upon the patient's treatment. This schema is applicable to all treatment-supervisory transactions and takes on a fascinating dimension in cases in which patient, therapist, and supervisor differ racially, ethnically, or culturally. While conscious and unconscious factors enter into the patient-therapist relationship, they are also present in the therapist-supervisor situation.

dream prior to the ending of supervision attests to how loaded the material was, but also calls for a redefinition of the triangular schema described earlier. In those instances in which the therapist is in his/her personal analysis or psychotherapy, the interactive schema becomes:



Case Example #2:

A Black female resident doing her training in a predominantly White urban residency program expressed her regret to the director of training that there was no African-American supervisor on the psychiatric staff; for she felt that she could profit from that type of supervisory experience. The director of training suggested that she locate an African-American psychiatric supervisor and if he met the supervisory qualifications he would be appointed to the training staff. She approached me and I agree to supervise her. She and I worked together for two years on a weekly basis and during that period she developed professionally and became one of the outstanding trainees in her program. During the second year of supervision she wrote articles for a popular magazine and for a professional journal. One of her articles was entitled "*Race and transference issues in the therapeutic relationship*" (Harris, 1990). Her identification with her supervisor is obvious and positive.

E. TRANSFERENCE AND COUNTERTRANSFERENCE:

The cases described in the latter part of this presentation will provide excellent examples of transference and countertransference responses in treatments in which therapist and patient differ racially, culturally or ethnically. There are a number of hypotheses that grow out of our understanding of the interplay of these issues:

> Transference to a therapist or mental health provider who differs racially, ethnically, or culturally from the patient will frequently utilize the most prominent stereotypes, myths and fantasies regarding the group of the therapist. The stereotype or myth represents a projection onto the minority individual of traits that are unacceptable to the majority person. The selection of a particular myth or stereotype is not random; but represents instead a choice determined by the patient's key psychodynamic and represents a vehicle for the representation of that psychodynamic or the defense against it.

One of the patients described in detail later complained of sexual inadequacy which paralleled his self-esteem impairment, sense of inadequacy and his vocational and social ineptness. Early in the treatment he brought forth dreams and fantasies in which the Black therapist was depicted as a sexual superman, conforming to racial stereotypes regarding sexuality in Black men. The racial transference allowed an opportunity to focus on one of his problems utilizing the anxiety generated by the frightening image of his therapist. While Schachter and Butts emphasized the catalytic effect of the racially expressed transference, it is also apparent that such a transference manifestation (by widening the gulf between therapist and patient) serves also as a resistance which must be analyzed as that.

In the case of the therapist's countertransference to his or her patient the mechanism is much the same as above. Cultural myths and stereotypes are used in the service of

presenting aspects of significant individuals from the therapist's past. Unresolved neurotic conflicts in the therapist result in countertransference problems. The myths and stereotypes used in transference whatever the race, ethnicity or culture of the therapist, patients will utilize racial transferences as a means of either resisting treatment or facilitating the process.

CASE # 1

An attractive 32-year old Jewish school teacher entered bi-weekly psycho-therapy after having had three years of analysis with a White analyst. She had sought help initially because of frigidity, vocational dissatisfaction, depression, and anxiety. In the course of that analysis, her vocational adaptation improved, her depression disappeared, and her anxiety diminished. She remained frigid, however, and unmarried, The major difficulty remaining after the three year analysis was her fear of giving up the child's role in relation to men.

She was born and reared in New York, the oldest of three girls. Her father was a somewhat cynical, successful lawyer, her mother was described as a cold, frigid, materialistic matron. The patient was cared for by a succession of maids until the age of eight. Between the ages of eight and fifteen, she was cared for by one Black maid with whom she established a warm and meaningful relationship and to whom she turned for warmth and dependency because of their mother's inaccessibility. In general, as a child, she did not express anger openly, and her parents were constantly critical of her inability to be openly affectionate. She and her mother perpetually quarrelled over her grooming and deportment, with her father supporting her mother in these disputes. She had no memories of the birth of her sister when she was seven years old. Her reactions of rage at the time of her second sister's birth, when she was ten, were displaced, onto the older sibling. As a child she wanted to be a boy, and felt that menarche made her "dirty". She was always concerned about the value and importance of money. She was a pudgy adolescent who read voraciously, had few friends, and did not date. Throughout adolescence, she felt that her parents were dissatisfied with her physical appearance and her inadequate social adjustment. After graduation from college, she attended and graduated from law school. At the age of twenty, she married precipitously. Her dissatisfaction with her marital sexual adjustment caused her to seek brief psychotherapy after she had been married for one year. Two years later she obtained a divorce. Her vocational, social and sexual behavior deteriorated, she became progressively more depressed, and sought therapy again at the Psychoanalytic Clinic.

Key among her dynamics, when she entered treatment with me, was her perception of men as destructive because of her projected rage. Rejection by the therapist was perceived by her as safer than dependency upon him. Vocational success was viewed as a renunciation of her femininity. Again, the most striking feature of her life adjustment was her failure in virtually every area of behavior, vocational, social, sexual, and family life. She felt disliked and rejected by everyone, and her hostile, provocative behavior tended to bring about rejection. The closer she approached adult womanhood, the more frightened she became of the consequences, namely a destructive sexual assault by a man. She rejected her feminine feelings and became aware of and anxious about sexual interest in women.

The analyst's anticipation of the development of a strongly erotic transference accompanied by intense anxiety was soon borne out, but her initial gambit consisted of applauding the therapist's empathic ability with the statement, "Negroes have guts." She had wound up the previous three year analysis as she was beginning to express affection and to get closer to people. There, the Oedipal implications of being "number one" were frightening, and she had created obstacles to block her awareness of the positive-affectionate tie to her father.

The selection of a Black analyst was multi-determined. In part it reflected a need to select a person whom she regarded as being the antithesis of her cold, distant father, thereby avoiding the anxiety of the oedipal striving for her father. The early parent-child power disparity was also reflected in her choice, in that she saw herself in association with an "underdog," whom she felt would understand her disenfranchised position in her family. The selection of a Black analyst was motivated by a wish to utilize a counter-phobic defense to deal with her sexual anxieties. She was overtly seductive, while expressing anxiety lest her sexual wishes be realized:

> **DREAM**: At an isolated house in the country with a man. Nobody was there but then a maid came down and motioned upstairs. I was frightened to be there alone with him.

She placed her hand over her pubic area as she related the dream and associated to the isolation of the analytic situation. A series of dreams followed in which she depicted herself as deprived and losing in the oedipal struggle.

> **DREAM**: A doctor was getting ready for a skiing trip. He was on the porch with his children and his wife. She had dark hair.

The therapist utilized the transference to demonstrate her renunciation of her femininity lest she be damaged sexually; her ability to function independently without dependency on her mother; and her ability to form a therapeutic relationship not predicated on the exchange of sexual favors or on her parentifying the analyst. Her pain-dependent, self defeating behavior was interpreted repeatedly. The therapist's genuine interest in her welfare was questioned by her from the outset of treatment; she identified him with her

presumably indifferent, unaffectionate mother.

The two years of treatment resulted in a modification of her affective symptoms, and an increase in her self-esteem, with a consequent diminution of her self-defeating behavior. She was married six months after termination of treatment.

CASE # 2: A WHITE MAN ANALYZED BY A BLACK MAN

A thirty-five year old White professional man of Jewish extraction and referred by his cousin, a former patient of the analyst, sought analysis because of his inability to get married. During each of two engagements he had become progressively depressed and anxious and in each instance had broken off the relationship. A second complaint, premature ejaculation, had begun a year before the patient sought help. Vocationally, he was insecure despite the fact that he worked in an executive capacity. He was ingratiating with fellow employees and fearful that he might not be able to control his anger in work situations.

His most vivid memories of early childhood dated back to age six, with recollections of visits to his White Jewish aunt and grandmother in Harlem. He took pride in making the subway trips alone, but recalled mixed feelings of anxiety and excitement. The Harlem community of that period was racially integrated. His anxiety was predicated upon his fear of physical attack, and his excitement seemed rooted in sexual fantasies which utilized racial stereotypes and myths.

An intense fear of losing his parents pervaded his childhood. He was a good student and active in athletics, but frequently needed his mother's intervention on his behalf during altercations with other children. At home, his mother was a severely critical, domineering, anxious woman, who subjugated her husband and chided him for being weak, inadequate, and a poor provider. She lamented her difficult lot in life and confide the intimacies of her marital dissatisfaction to the patient. The father was physically and emotionally inaccessible.

Castration anxiety increased at age fourteen when his parents concern about the size of his penis led them to consult a physician. He was embarrassed to shower with schoolmates for fear that they would discover that his penis was small. Adolescence brought sexual interest and exploration; he dated, was always inhibited and anxious. During this period he shared his sister's bedroom but recalls only one instance of embarrassment, when she giggled on overhearing him masturbate.

Concern about the size of his penis persisted into adulthood. After completion of Army service and college, he worked in an executive position, continuing to live with his parents. He perceived phallic women as castrators, and used prematurity and impotence to defend

against castration. With men, he was "the nice guy," obsequious, ingratiating, and controlling of his rage. His nonassertiveness socially, sexually, and vocationally were derivatives of his need to control his rage.

Early dreams gave form to the negative transference of the first six months and highlighted one of the patient's key problems: The Black man was presented as physically assaultive, drunk, and debased, and the patient feared his analyst's aggression and sexual exploitation.

In his association he dwelt on the theme of the menacing Black, juxtaposing his sexual inadequacy, fear of women, and his perception of women as castrating, humiliating creatures. Soon after beginning the analysis he moved from his parent's home, magically utilizing the therapist's strength as a buffer against his mother. The move was accompanied by a great deal of anxiety, represented in dreams as a fear of starving to death. He began to date and to attempt sex, expressing his lack of assertiveness and his dependency orientation in dreams such as the following:

> **DREAM**: In my apartment with C. we were necking. I had her breasts in my hand. There were many women around. They were exposing their breasts. I was completely fascinated and felt pressure.

The therapist challenged his fragmented view of women and its emotional counterpart, his affective isolation and his wish to present himself as dead emotionally. His dreams and associations were replete with his wish to be regarded as a helpless infant, which was interpreted, at that time as a defensive retreat to a position of dependent safety designed to avoid castration. The patient was then able to associate this with his difficulty in separating from his mother to attend kindergarten.

Ten months after the beginning of the analysis he triumphantly reported that he was able to penetrate a woman sexually despite intense anxiety and fear of impregnating her. He plied the analyst with questions about contraception, in actuality seeking plaudits for his sexual accomplishments. The analyst's mild disbelief in the therapeutic significance of the patient's achievement in part reinforced the patient's stereotyped perception of the Negro as a virtual sexual superman, thus widening the gulf between analyst and analysand.

Another source of difficulty during this period was the analyst's need to disclaim his therapeutic power to achieve such a great effect with the patient. This problem was rooted in the analyst's insecurity about his effectiveness which was combined however, with a need to assert his greater power over the patient.

With continued attempts at intercourse, a pseudohomosexual theme emerged in a dream:

> **DREAM**: I was in bed with S. She got on top of me. We were having intercourse. But it was not S's face. it was a man's face. I was frightened.

He discussed the anxiety in the dream, adding, "I'm afraid of women so a man is safer. But why am I afraid of women? My mother is a woman."

The second year of analysis was concerned with his efforts to separate emotionally from his parents, to improve his sexual adaptation, and to deal with his chronic anxiety. During this period he maintained a relationship with one woman, advanced vocationally, and began to see himself as having an existence separate from that of his parents, with lessening anxiety about their death. References to the therapist's race were minimal, although when the patient's fear of the therapist mounted, the menacing Black would reappear in his dream life:

> A Negro trooper strikes a White policeman in the stomach. The White man beats him up.

Increased separation from his family brought mounting anxiety about his relationship with the analyst, and he reconsidered his childhood visits to his aunt's home in Harlem, which were marked by a mixture of pleasurable excitement and fear. The omission of his father's role in the family, previously justified by his father's absence at work during the patient's childhood, became a therapeutic focus, particularly since any information about father had been transmitted by mother. During the latter part of the second year of analysis, material emerged indicating that his father had protected him against the mother and against destructive women in general. His dreams became less frighteningly destructive and he dreamed of father and therapist in terms of helping figures. He was married in the third year of analysis and terminated six months later. His functioning had improved considerably in all areas.

CASE # 3. A BLACK MAN ANALYZED BY A WHITE WOMAN ANALYST

An unmarried man of mixed Black and Caucasian extraction entered analysis at the Columbia Psychoanalytic Clinic because of his inability to form a stable relationship with a woman, and increasing awareness of his inability to face marriage. He was also troubled by difficulties at work, particularly with a woman supervisor, which had contributed to his recent loss of a job. He was unable to express his feelings or to tolerate the expression of feelings by others, and appeared passive, isolated, and dependent upon his mother.

Early childhood was spent in a White commercial neighborhood in a northern city, living in the maternal grandfather's home with his light-skinned mother and father.During the Depression, the family moved to Harlem. Thus, at six, he believed that it was his dark color that necessitated the family's choice of home. At twelve to thirteen years, he was the successful vice-president of a gang because of his boxing skill, and two years later he was caught in his first serious delinquency, pilfering from the mail. After high school graduation he got a construction job and began passive homosexual activities in toilets, apparently after his mother arranged for his girlfriend's abortion. On the job he suffered a minor injury, and during the subsequent hospitalization he applied to and was accepted by a large Negro college out of town.

Once there, he lived with an older woman off campus and avoided both school contacts and fraternities, which were divided on color lines. He associated only with men who were appreciably darker than himself. After graduation, he returned to his mother and sporadic employment until he was encouraged by a supervisor to take up his work seriously. In his first year he was successful and well liked and, after applying for analysis, finally moved into his own apartment, distant from employment and Harlem. He subsequently noted tenseness, frequent masturbation, difficulty with his girlfriends, and then with his woman supervisor. He had lost that job before his analysis had begun.

During the historical recounting in the opening phase of treatment, the patient used Negro stereotypes to fend off the analyst. For example, he described how he had been asleep at the wheel during an accident in which a male friend had been killed and a girl injured. He sought to impress the analyst that his subsequent behavior toward the injured girl passenger involved minimal guilt and maximal undependability. During this period of treatment, he also acted out by attempting intercourse with his stepmother's sister, related several incidents in which he presumably had gotten girls pregnant, and recounted several "rape attempts." He was finally able to recognize his desire to scare the analyst by exaggerating the material, "You won't like me as much...do I want to be rejected and construct a situation?" At the same time, his directly verbalized anxieties about rejection related only to the building doormen and his feeling that he might be stopped on entering the lobby.

Dreams of the possibility, as well as the dangers, of a real concern for and attachment to a woman occurred shortly before he verbally recognized the analyst's pregnancy. Not only feelings of loss, but also those of considerateness were mobilized for the first time. When treatment resumed, he dreamed he was attempting in vain to find his Spanish class, which he identified with passing. He felt that the analyst accepted the self-stereotyped rejected part of himself that he characterized as Negro. He later quired, "I wonder if my coming to treatment would tend to make me feel equal to White." He became increasingly involved with color and in a dream indicated that Negro children and White women, including his mother, could be assertive because they had rights, while he, as an adult Negro man, had none.

He insisted that he was basically ill-equipped for life, that the burdens of color and a poor cultural heritage increased his vulnerability, and that the analyst's attitude that he could make it only indicated how little she understood. At the same time, trust and mutuality developed through a discussion of The Invisible Man, which served as a vehicle for expression of his fears that the analyst would be paternalistic in setting his fee. For the first time he contemplated working in Harlem and enlarged upon the Negro stereotype. "I've never worked around many colored people. I have stereotyped ideas of what the people would be like...more impulsive, physically impulsive, likely to hit out...I see Whites as having more controls over themselves."

Near the end of the second year of analysis he began an affair with a blonde White woman co-worker, and during the analyst's second pregnancy he verbalized his feelings more meaningfully, and began to use insight to control himself. "What kind of woman do I want...someone like you. I'm not going to get it while I'm doing all the taking." The analyst demanded that he recognize and not give in to his impulse to change all his relationships with women into sexual affairs, despite his increased awareness of anxiety and anger. He made an abortive attempt to escape into marriage, then returned to examine his feeling that he lacked the equipment to explore reality and his stereotypes. Months of angry resistance followed during which he repeatedly enunciated his desire to get what he wanted as a gift. Finally, however, he accepted the overtures of his White employer who became the first woman outside analysis with whom he had a friendly, nonsexual relationship. This brought color specifically back into the analysis, and after he invited her out to dinner he dreamed that he was castrated and had his penis in his hand.

At the beginning of the fourth year of his analysis he met the young Negro professional woman he married two years later. She was presumably engaged to a very light-skinned Negro man in a position of social importance, and he both acted out his oedipal anxieties and became aware of them in the transference. The use of color as a barrier to sexual impulses to mother was further explored since it included his picture of father, the Negro, as neither gratifying mother nor able to serve as a model for control of impulses, thereby exposing the patient to his sexual desire for mother. At the same time, he felt that he had to lose out to a light-skinned man and could win only if he associated with darker people. "I get angry at all White people and have to think a second time." His attempt to exempt

the Jewish analyst because of similarity in minority status was confronted by the distinction between our social problems as well as his need to obliterate differences. As he grappled to understand the nature of the sexual barrier between us, and between him and mother, he repeatedly came back to color. In a dream, the slow analytic train was held up by White barriers, which represented the analyst, who would cause the crash and hurt the driver. Furthermore associations were to the analyst's open and free attitude toward color in comparison to his own feelings of prejudice against dark women. His angry self-justification was: "You've had a better life than I....You can afford to be more liberal, freer of prejudice than I. How can you understand what it is to be a Negro in America...a bitter thought...it's one thing to see something from the outside and another to live within it."

During the last year of treatment he re-examined why the analyst was not afraid of his impulses, or him. "The only reason I can think of your being scared is because of color; it's the way I separated myself from my mother. I associate all my failures with color. My uncle drove a coal truck and was dirty and I identify him with color."

Settings his wedding date precipitated more anxiety, focused now on fears of having a dark child. He was forced again to face his prejudices and his feeling that his child would make him more identifiable, as did his fiancee, who was approximately his color and had a "pug" nose. At the same time, the realities of his life made him more aware of his opportunities. The pleasures ahead of him, and guilt at leaving the analyst as well as his parents behind, became the final theme of the analysis.

Follow-up has shown that the patient has consolidated the gains made in analysis. The opening up of his ambitions, particularly in the beginning of the sixth year of analysis has expanded to active and successful work. He sees himself as a leader in his profession and of his race. His marriage appears stable and successful. Although he was momentarily upset at the birth of a child lighter than either he or his wife, he recognized and coped with these feelings, identified the child as his own, and made plans for another.

CASE # 4. A BLACK MAN ANALYZED BY A BLACK MALE ANALYST (BRIEF VIGNETTE)

Although accorded scant clinical attention the therapeutic situation in which both therapist and analysand are Black contains both positive as well as resistant features. A 28-year old Black social worker sought professional help because of feelings of professional and personal inadequacy, periods of depression and anxiety and marital discord. His past history in brief was characterized by an ambitious drive to achieve and gain recognition, combined with a self-defeating sense of inferiority which during childhood had been reinforced by the negative responses of his siblings and by often covert rejection by his parents. He approached the therapeutic situation with an optimism which was enhanced by his therapist's Blackness and the unconscious, but later stated impression that he (and his difficulties would be immediately understood and magically resolved without the need for his active participation in the therapeutic process). In transferential form, he soon began to express feelings of inadequacy an inferiority viz a viz the therapist and to experience a rapid and malignant pseudo-homosexual anxiety with respect to his therapist, based on his resort to myths and stereotypes about the supermasculinity of Black men. What began as a quasi-alliance aimed at his personality reconstruction soon evolved into marked resistance, panic and feelings of distrust bordering on paranoid behavior. It was virtually impossible to examine and resolve these conflicts, and the treatment was terminated by mutual consent.

I made an earlier reference to the confluence of psychoanalysis, literature, mythology, sociology, anthropology, politics, economics, as important parameters in the inter-racial therapeutic situation.

PROPOSAL:

There are several recommendations implicit in much that has been delineated up to this point. These recommendations are posed with a full realization that there are realistic constraints rendering several difficult to implement; but no recommendation should be rejected. Instead, efforts should be made to modify or remove those constraints. The

recommendations may be divided into the following categories: Staffing, treatment, training, supervision.

I. STAFFING:

1. The staffing pattern of mental health care facilities should parallel the ethnic, racial, cultural patterns of the patient population serviced.
2. To implement "1" each facility should institute a recruitment committee for ethnic balance that would assist the administration in recruiting, screening, and hiring staff; as well as provide a "watchdog" function.
3. Each facility should enter into third party payment plans so as to make psychotherapy available to all of staff. Staff should be encouraged to utilize the benefits for psychotherapy.

II. TRAINING:

1. Training facilities should embark upon a diversity initiative that provides: regular ongoing seminars, lectures, and workshops related to each ethnic, racial group being serviced at the facility.
2. The establishment of a training committee is recommended. That group would have the responsibility of establishing curriculum, evaluating curriculum and recommending curriculum reform to the clinic director. Members would be

appointed by the Director with an eye to the diversity of membership.

3. Formal courses for staff including:

    Comparative Ethnology

    Racism

    Hispano American, African-American, Native American - history courses

    The Psychology of the Black Experience

4. Establish a specific ethnicity lecture services
5. Provide a mechanism for liaison with other ethnicity diversity programs-share the experience.

III. TREATMENT:

1. Adopt measures that will insure ethnic, racial and cultural diversity in patient population.
2. Make assignments to therapy staff so as to result in heterogeneous pairings.
3. Establish a conference format in which ethnicity, race, and culture are incorporated into patient evaluations and psychodynamics.

IV. SUPERVISION:

1. Adopt measures that will insure ethnic, racial and cultural diversity in supervisory staff.
2. Assign supervisors so as to produce a rich and varied experience for trainees.

SUMMARY

As American society becomes increasingly pluralistic, ethnic, racial, and cultural diversities become the norm; further these diversities while constituting America's uniqueness and richness, represent an interpersonal challenge in many areas of life. In psychiatric practice cultural diversity in simultaneously a barrier to treatment as well as a treatment facilitator. This paper represents an examination of the clinical, training, staffing and supervisory implications of cultural diversity. In addition, to an extensive review of the relevant literature and case examples, recommendations are advanced for dealing with diversity so as to view it as a clinical issue warranting understanding as opposed to fear and avoidance.

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MINORITY MENTAL HEALTH NEEDS AND PRIORITIES

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I would like to say how pleased I am to be here with Dr. Ross and with Jessie who I recently saw in New York City. It's also good to be with Bill Morris and all the MERTI staff people, whom I consider to be family.

Today, I want to talk with you about the need for culturally competent mental health care. As America's urban centers grow more ethnically varied and as the nation as a whole becomes less homogenous, mental health services must be premised on a set of behaviors, attitudes and policies that enable professionals to work in a culturally diverse atmosphere.

To achieve that, we must reexamine some of the eternal verities that guide mental health professionals. We must look anew at our underlying theories to insure their continued relevance and acknowledge that they are not etched in concrete. Over 100 years ago, Dr. Oliver Wendell Holmes, the great American jurist, noted that:

> "Medicine professedly founded on observation is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density. Theoretically, it ought to go on its own straightforward inductive path without regard to changes of government or to fluctuations of public opinion. But actually, there is a closer relation between the medical sciences and the conditions of society and the general thought of the time than would be first be suspected."

This wise jurist's statement is particularly relevant to contemporary mental health care professionals. There is a predominant belief among psychiatrists, psychologists and social workers that universal scientific rules govern both behavior and mental illness. This unquestioned assumption has not worked to the benefit of minorities.

Such a belief ignores the role of society and culture in psychosocial and personality development. Moreover, it fails to address the interconnection between culture and behavior. It does not take into account significant differences in child rearing practices, family structure or adolescent and adult development found among the various racial and ethnic groups in this country. By focusing solely on what makes all of us alike, predominant mental health theory ignores those crucial variables that make us unique and different. Clearly, those whose collective experience diverge most drastically from the group on which the theoretical model is premised, benefit least from traditional treatment.

How has this occurred? Much of the answer can be attributed to the predominance of Freudian theory and dynamics and to how American psychoanalytic and psychosocial theorists have interpreted Freud's ideas. Despite continuous challenges to Freud, we have failed to fully consider the extent to which his writings were colored by the culture and time period in which he lived. How much of Freud's work reflects his experience as a member of Vienna's late nineteenth century bourgeoisie and how much is applicable to all people through all time?

Think for a moment of the day-to-day reality of working with patients from different racial and ethnic backgrounds. Practical experience makes it readily apparent that culture plays a role in behavior and that an awareness of culture is a vital component in the treatment process. To accept that position does not lead us into the trap of cultural relativity. Rather, it allows us to broaden our theoretical base and develop more sophisticated models of behavior. By acknowledging the importance of diversity and difference, we can address reality.

The inapplicability of traditional psychoanalytic theory to minority group members has meant that mental health professionals have put greater stress on the control and management of patients than on their treatment. Hospital staff often erroneously perceive minority patients to be more violent than whites. That perception, in turn, leads to increased reliance on medication and seclusion orders. There is also a pronounced tendency to misdiagnose the illnesses of minority patients. No one should be surprised that minority

group members are often found to be sicker than whites and to require longer hospital stays.

Let me give you some statistics that illustrate these points. The admission rate for African Americans to state and country mental hospitals is 367.5 per 100,000. Yet, it is only 159.7 for whites. 34.3% of African Americans admitted to such hospitals are referred by the police, the courts and correctional agencies, while only 27.2% of whites are referred by these sources. Slightly less than a third of all white admissions to state and county hospitals were diagnosed as schizophrenics but 36.3% of admitted Hispanics and 44.9% of admitted African American received that diagnosis.

Additional statistics would only add emphasis to the central point which is that culture, race and ethnicity cannot be divorced from the etiology and treatment of mental illnesses. While research on ethnicity and mental illness remains inadequate, what is known tends to highlight the importance of culturally competent care.

Schizophrenia, for example, manifests itself differently based on ethnicity and race. Asian American schizophrenics reveal a higher level of paranoid behavior than other groups. African American schizophrenics are prone to exhibit symptoms more in keeping with chronic undifferentiated symptoms. Differences also exist with regard to depressive disorders. Hispanics tend to express depressive symptoms in terms of body aches, feelings of weakness, exhaustion and fatigue. Blacks tend to hallucinate more.

The need to make mental health care relevant to diverse populations is not new. Unfortunately, racism and antipathy to immigrant groups have historically effected the diagnosis and treatment of mental illness and quality of care. Let me illustrate this problem by introducing you to two 19th century diseases that no longer seem to plague African Americans. The first is ***Drapetamia***, an illness that caused slaves to run away and the second is ***Dysaethesia Ethiopica*** which caused slaves to waste and destroy everything they handled.

Both of these "illnesses" were discovered by the prominent antebellum southern medical doctor, Samuel Cartwright. Clearly, Dr. Cartwright's rather creative and curious maladies illustrate precisely how culture shapes our understanding of illness and health. They also illuminate how theories of mental illness can be used to reinforce biases and maintain order. To further explain this point, I'd like to talk a bit about the historical development of minority mental health epidemiology in this country.

The first significant study of the mental health of African Americans appeared in the 1840 census which was directed by a southern supporter of slavery. Census results clearly reflected the ideological concerns of southerners aware that slavery was under attack and seeking an intellectual defense for this peculiar institution. Not surprisingly, data generated by the census revealed that African Americans lacked the capacity to live a free men. By inference, it could be assumed that slavery fulfilled a larger social good, providing African Americans with the structure and order needed to prevent mental illness.

Edward Jarvis, a well respected 19th century psychiatric epidemiologist discovered that the data used to make these arguments was false. Nonetheless, the 1840 census continued to be used as evidence, first to support slavery and later to buttress segregation and paternalism.

There is something else that we can learn from Jarvis. For all his devotion to scientific inquiry and to humane psychiatric care, Jarvis was not untouched by prevailing theories of race and ethnicity. Like Dr. Cartwright, he was a creature of his time. Jarvis lived in Massachusetts, a State that absorbed large numbers of Irish immigrants from the 1820s through the 1840s. Like much of the country today, Massachusetts evolved from a homogenous population to one that was more diverse and that produced conflict. Commenting on the mental health of these new Americans, Jarvis noted:

> "There is good ground for supposing that the habits and condition and character of the Irish poor of this country operate more unfavorably upon their mental health and hence produce a larger number of the insane than is found among the native poor. Unquestionably, much of their insanity is due to their intemperance to which the Irish seem to be peculiarly prone and much to that exaltation that comes from increased prosperity."

Please consider for a moment how this kind of attitude effected the treatment of the mentally ill Irish immigrant. The image of the 19th century mental institution as a hellish warehouse was no doubt the product of a mental health system unwilling to accept an alien and impoverished immigrant group. There are striking similarities between the experience of the Irish in the 19th century and those of African Americans, Hispanics and Native

Americans in our time.

By the end of the late 19th century, psychiatric epidemiologic literature became more sophisticated and factual. However, methodological errors remained and studies continued to be biased. Invariably, they reached conclusions that reinforced stereotypes about racial and ethnic groups. Studies of immigrant groups including African Americans, for example, consistently revealed a higher proportion of mentally ill people than the population as a whole. They did so, however, by using only treated cases to determine prevalence rates an by failing to correct for the differential access of these groups to public and private treatment facilities.

These studies were interpreted as further evidence of the inherent biologic inferiority of certain ethnic groups. White psychiatrists reported clinical studies of immigrants and African Americans that uniformly concluded that they had primitive personality structures. Their findings matched the research of other professionals. Biologists, for example, stressed difference in brain size between whites and African Americans. In the end,
all of these studies reaffirmed society's belief that immigrants and former slaves could not assume the responsibilities of full citizenship or participate equally in the workplace.

By the middle of the 20th century significant changes in how society perceived minorities finally caused psychiatry to reexamine some of its basic conclusions about race and ethnicity. The development of more sophisticated survey techniques also helped change

views. Community based surveys eliminated past methodological failings. With these new research tools, it became apparent that no meaningful difference existed in the mental health status of whites and African Americans, except those that could be attributed to socio-economic variables.

Let me conclude my remarks on epidemiology by saying a few words about the National Institute of Mental Health's epidemiology catchment area study which involves 3,500 subjects in five cities. The Institute is seeking a national portrait of mental illness. By focusing only on samples of urban, poor and non-institutionalized minorities, it will not provide an adequate or comprehensive picture. We can and should do better.

I now want to say a bit about diagnosis and treatment. As I noted earlier, research has repeatedly revealed that minority group members are at greater risk of misdiagnosis than whites. Psychiatrists are far more likely to diagnose schizophrenia in African Americans and less likely to diagnose depression. In the case of Hispanics, diagnosis is often complicated by language problems. When standardized diagnostic systems are used, differences in prevalence rates between minorities and whites disappear.

The diagnosis of minority group members is also affected by the fact that symptoms also vary based on race and ethnicity. Hispanic patients, for example, often fail to recognize anxiety despite experiencing what are often considered to be standards symptoms like heart palpitation, dizziness and fainting. African Americans with affective diseases tend to

hallucinate, have more delusions, somatize more and exhibit more hostility than whites. On the other hand, whites tend to exhibit more mania, depression and guilt.

It is important to remember that diagnostic tests need to be validated for minorities. We cannot just assume their accuracy. This has happened repeatedly and the result has made it more likely that minorities will be misdiagnosed. African Americans, for example, score higher on the paranoia and schizophrenia scales of the psychological test, the MMPI. Does that mean that they are more paranoid or more severely schizophrenic? This was the initial interpretation. In reality, it simply meant that the instrument had not been standardized for the African American population.

The same problem exists with regard to using biological markers for diagnostic purposes. Researchers found that serum creatinine phosphokinase is increased in some acutely psychotic patients. However, they initially failed to discern important differences between whites and African Americans. As it turned out, serum creatinine phosphokinase is significantly higher in healthy African Americans than it is in healthy whites. Another example, is that African American schizophrenics have higher platelet serotonin levels than non-schizophrenic African Americans. Yet, it is not the case when schizophrenic whites are compared to healthy whites.

After all of this, it should not be surprising that different racial and ethnic groups respond differently to psychotropic medications. In a seminal 1982 article, ***Ethnic Difference in Drug Metabolism***, Kalow shows that differences in metabolism among ethnic groups are

quite common and this has important implications when prescribing medications. Let me give you some illustrations. In the third world, dosage levels of neuroleptics are far lower than standard doses in the United States. Hispanics require smaller doses of anti-depressants and other medications. In fact, Hispanics experience more side effects from psychotropic drugs than anglos even when medications are reduced to half the standard dosage.

Whites and African Americans also react differently to the same medications. Phenothiazines and tricyclic anti-depressants are more effective with African American schizophrenics and depressed patients than with their white counterparts. African Americans also experience more anxiety reduction with anti-anxiety and anti-depressant agents. They show more improvement with a tricyclic than whites.

All that I have discussed with you today, highlights the importance of providing culturally competent mental health care. Psychiatrists, psychologists, social workers and other care-givers must learn to value diversity and to incorporate an individual's cultural heritage into the therapeutic process. Let me give you a personal anecdote based on my own therapy to illustrate how significant this can be.

When I got out of the Army, I returned to the same therapist I had seen before my enlistment. He was white. Friends suggested that I might benefit from an African American therapist and my therapist also thought that such a change might be beneficial.

I began seeing an African American analyst. One day I was talking about my grandmother and referred to her as "big mama," a common descriptive term among African Americans. It is a term that too few white therapists know.

The more I thought about it, the more I became convinced that not having to explain the reference to my therapist was quite important. Having to interpret something so basic, affirms a patient's worst fear that the therapist and the patient are different. Too often patients equate being different with being inferior and this has a particular relevancy for minority patients. The failure to understand a simple reference, in fact, can make a patient question the therapist's ability to understand more significant issues. A lack of cultural competence can undermine the entire therapeutic process.

How can we improve the cultural competency of mental health services? Let me leave you with several suggestions:

- We must rely on community-based services.
- We must promote interagency collaboration utilizing natural helpers and community systems.
- We must stress early intervention and prevention.
- We must define "normal" within the content of the client's culture.
- We must develop adequate cross cultural communication

skills.

- Finally, we must seek to attract and retain more minority mental health professionals.

Mentally ill minorities have more than their illness working against them. In today's America, being African American, Hispanic, Asian American or Native American vastly increases the odds that mental health care will be inappropriate. This has been the case historically and, while much has improved, the playing field has not become equal. We have the knowledge and the ability to change that. Hopefully, minorities will demand cultural competence and refuse inferior care. In doing so, they will improve their own health and create a healthier society.

Thank you.

QUESTIONS:

1. **(Q)** Can you address the issue of the distinction between distrust and paranoia in culturally different individuals. Often times African Americans are given the label of paranoia by persons who happen not to be African American and in many instances the issue is realistically based on distrust.

(A) It is what Greer and Cobbs talked about as cultural paranoia, in the book "Black rage" - a defense mechanism? If you want to conceptualize it in

psychoanalytic terms, a defense mechanism that African Americans use to manage in a society that generally discriminates and has some inherent dangers associated with the process of discrimination. One approaches situations with a certain amount of suspiciousness and caution when involved with individuals from different cultures, than yourself, ie. White culture. Most Blacks in this country would have some degree of reservation and suspiciousness when sitting down with a White therapist. Their life experiences have re-inforced feelings of discomfort in relating to or completely trusting the White therapists or any White person with particularly important, confidential and private information. Hence, a kind of healthy suspiciousness is used as a protective mechanism which is different from true paranoia. The fact that someone does not necessarily trust you in an evaluation may be quite a healthy sign, given the reason for doing the evaluation and/or what they perceive as the reason. The perception of the reason for doing the evaluation, the role the evaluator is playing and the patient's perception of that role is just as important to them as the verbal exchange and stated purpose of the encounter.

2. **(Q)** What do you think of the concept of cultural competence now that it includes bilingual competency. Certainly, in Native American communities, certain feelings cannot be expressed in English. I always think of that scene in Silence of the Lambs where Hannibal Lector says you are trying to dissect me with this blunt instrument. English is a very blunt instrument. Certain languages are much more subtle. What do you think about this challenge now that cultural competent you (Dr. Jones) have

to divide (yourself) bilingual-trilingual as an analyst.

(A) Well, I think that is certainly true. I think that one would want to capture certain nuances, tones and verbal inflextion which are lost in the translation from one language to another. You really can't. Liberal translations do not give the correct emphasizes, or adequate connote the correct feeling that is being expressed. It is more than just being able to understand the words, but the meaning and the cultural significance of it as well. I am not sure that one can do it, certainly if an interpreter is used. Translators don't work and many studies exist that underline the problems with translators. Too much is lost in the process. Most of us, myself included are monolingual having grown up speaking English and it is grandiose to feel that this is sufficient when most of the world speaks a lot more than just one language. In order to do a good job with patients who are from a different cultural backgrounds and speak a different language, one does not only need to speak but to master the intricacies and colloquialisms of the language as well.

3. (Q) Why do Black workers, mental health workers, see Black patients as being violent.

(A) Studies have indicated that this is not necessarily the case with Black women patients but is the perception of the Black male patient, as an inherently violent individual. I think it is an extension of society's views that the African American

male poses a violent threat. The number of African Americans in prison is used as a justification of this view. The problems that young African American males face in the school system is another illustration of this implied threat. African American teenage males tend to exhibit more physically active. They talk more with their hands and motor behavior tends to be more active. I believe that these physical manifestations of African American teenagers translates differently to White society than the behavior of comparable White male adolescents. In analyzing the physical manifestations of African American teenagers, we see that quality of talking resembles shouting and there is a tendency to get louder, easier and quicker. These actions translate into a concern or fear of physical action, in anticipation of what is going to happen next and that means an outward display of violence. It is also related to the past historically and one needs to be concerned about retaliation by the oppressed at some point. I feel that these historical vicissitudes are operative as well.

4. **(Q)** There was a recent mini television series ***Separate but Equal*** where a White man came from Texas to work with Thurgood Marshal at the NAACP Legal Defense Fund.

He was asked why he would want to work with them. During a heated exchange his comment was that among his friends and law school students there was a known fact--that in the legal offices of the NAACP in New York there were hooks on the walls with hundreds of keys to the bedrooms of all the White women in the

South. If that was true, it was exactly the place where he wanted to work. It was a tension breaker but it also indicated something about the fantasies of his friends and peers about what Black people were about, especially Black men.

I'm getting a to a question that has to do with timing in terms of Black and Latino men being over represented not only in prisons, inpatient services and in emergency rooms, but how they are miserably under represented in our outpatient and day treatment programs and the issue is what happened? Why is it that programs do not seem to fit their needs or is it an assessment problem. Is it that they are untreatable or they are just bad and should be in jail. I am being facetious but I believe this is an issue we have to address.

(A) There are many reasons but part of it has to do with what most clinicians are taught. For outpatient treatment the so called "good patient" emulates the model treatment candidate with whom you can sit down and talk with, is motivated for psychotherapy, keeps appointments, follows directions and who is going to do all these sorts of things. Most patients don't fit the model but this is the psychoanalytic criteria of a good patient. When things go wrong, then is it really the patient's fault? What you are suppose to do is to get the patient to examine his/her behavior and its consequences. For the most part, this is not what works with most of the people that we have in the system now. I believe that these techniques have limited utility when you are dealing with African Americans and other minorities. One of the big problems is that they are turned off very early, even on the inpatient service about

mutual expectations in the treatment process - what is going to be like. Secondly, I don't think that we do nearly enough in the way of educating the patient to function in the therapeutic alliance. You need to educate any patient who comes for treatment. I remember when I started analysis - I didn't run in the room, lie on the couch and said okay I'm ready. I was a first year resident in Psychiatry at that time so I knew something about it, but initiation into the therapeutic process requires education of the patient. You have to go step-by-step, and meet the patient where he/she is. Negotiating the therapeutic landscape is a dual responsibility. You try to move patients to the point where they are receptive to make the best use of treatment regimen you feel is appropriate for them. We don't do that thus abdicating part of our responsibility. We go in and say this is what we are going to do and its almost like giving a prescription. This is the prescription and if the patient is not ready to accept that prescription as it is presented, it is their problem. We do not spend the time or we are unable to meet the patient where the patient is.

I remember as a resident an experience I had with a patient who lived across the street from the hospital. She was a Black woman, who had a multitude of problems. Her mother died after giving birth to her. Her brother, an older sibling, always told her that she had killed her mother. You can imagine the kind of problems that were generated from a very early age. She was very dependent on the hospital. Among one of her problems was excessive drinking. When she came to therapy she would be wreaking of alcohol; obviously we were not getting anywhere.

How can you conduct therapy with somebody whose drugged but actually has many real problems. We started by having her coming in on a regular basis to establish a relationship; to get her to develop some degree of feeling that she wanted to see me and this happened. Initially, I told her that I was not going to see her until she came in sober. She tested me for a while. When she came in drunk, I would say "hello but you're not sober and you've got to go home and come back when you are sober". Gradually, we got to the point where she said that she had difficulty talking with me face-to-face because transference material was surfacing. The solution to this dilemma was a mutual agreement to turn the chair around so she could talk but didn't have to look at me. I had a supervisor who as I presented some of these problems, said "I don't know what to do either but try some new things and let's see if it works." That was the most helpful information that anybody could have given to me. If he had focused on the drinking problem as an insurmountable resistance to treatment by saying you can't see this lady because she's a drunk, which is how most of us would react, and justified the decision the grounds of her not being a good patient and her inability to use psychotherapy, the end result would be to come for her medication. Thus, the fulfillment of a prophecy that this was the only expectation I had of her. We would have gone absolutely nowhere. I feel that we have to devise techniques of reaching out to patients and to embark with them on a voyage where our interdependence is emphasized as part of the therapeutic contract. Movement along a treatment continuum requires the flexibility to use a variety of skills not all of which will render profound therapeutic insights but will get

patients to the point of feeling better, mobilizing psychic energies and improving functioning. Even if total improvement is not forth coming at least the next time around there will be an easier engagement and hopefully better the therapeutic results.

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THE CURRENT BUDGET WAR AND ITS IMPACT ON MINORITY MENTAL HEALTH CARE

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141st ASSEMBLY DISTRICT
ERIE COUNTY

Albany is a disaster and there are more cuts in agencies probably more than the governor has recommended. I would like to just start off by saying we are in a financial dilemma because of a very excessive tax cut given in 1986 and 1987. Whether or not you earn $40,000, you pay a rate of 7.875. If you earn $400,000, you pay a rate of 7.875. If you earn 4 million dollars in this State, you pay a rate of 7.875. In 1987 NYS did away with progressive taxation, a tax which impacts more at a higher rate of income on those who earn less. Because we did away with progressive taxation, we are now facing 4.5/5 billion dollars worth of potential cuts. As a result, the rich got richer, the poor got poorer and middle income people are being squeezed to death. With the cuts that will be made in Albany a lot of the burden and responsibilities will be shifted to local government and that means that property taxes and other taxes will in fact go up. Many

of the services to children and to communities will be denied. This budget being put together not by raising personal income tax rates higher, for those who earn more or to expand the sales tax to include lawyers fees, accounting fees or to take away some of the tax loop holes that corporations get in this State at a tone of 300 to 500 million dollars. Instead of doing that we're going to use gimmicks, we're going to come up with fees, we're going to come up with all kinds of things. Imagine trying to come up with x number of dollars that we know will not be the number of dollars we say it will be.

This year it is a problem, next year there will be a problem and even the third year there will be a problem. Our State's method to diminish the number of people being laid off is to offer you early retirement. Many of the services and the bodies will be lost and those of you who are left are going to be asked to carry Herculean responsibilities with little resources to do it with. I would like to say that one of the ways in which many of us are trying to counter this is to develop a State wide coalition and as I said to Dr. Ross earlier, the attitude in Albany today is if the only thing holding up this budget was NYS workers being laid off, this budget would have passed April lst. However the governor hurt everybody including schools, hospitals, medicaid, homeless, veterans, senior citizens, and so on. The governor presented a budget to us that the only group who supported it 100% was the Business Council of NYS. They are the rich corporate executives that use to pay 13% taxes on their unearned income that they made on the Stock Market. Stock options and stock that the companies gave them, were traded and they made a bonanza. They use to pay a 13% tax in 1967, they now pay a

rate of 7.875% and so everybody whether or not you are working poor, middle income or wealthy, are all treated equally in this State and that means that the rich are doing very well.

So we are going to put together a Statewide coalition of people involved in education, ecology, homeless, veterans, and mental health patients bring them together to be involved in making the State more responsive. The first thing we want to do in a progressive tax system is to pursue those corporations in this State who get 300 million dollars in tax credit who, in fact, pay less in taxes than some of your families may be paying today. I want to leave that with you because as time goes on, there will those of us who will be coming to you saying "come and join us". We could begin working on this problem prior to the budget period to get to the legislators and make them understand that we cannot accept another round of cuts in the manner that the governor presented the budgetary dictum to be approved possibly this week or even next week. I want to discuss some statistics with you because of your concern with minorities.

25% of all AIDS cases in America are here in NYS and of that 25% make up the NYS AIDS population, of which 60% is Black and Latino. 31% of all of the pediatric cases of HIV infection and AIDS in America are in NYS. 91% of the pediatric AIDS care patient population are African Americans, Latinos and other minorities. We have the largest Tuberculosis population in America. 10% of all of the TB in the country is in New York City. In this State 50% of the Black and Latino youngsters do

not graduate from high school. We are now living in a society where technology in the form of video games generates more interest than homework in the period of life when a teenager does not graduate from high school and literally drops out of society. 50% of the teenagers who graduate from high school function at a ninth grade competency level and below.

That is not all accidental. The system is moving further and further away from meeting the needs of people of color in this State. The spin off of this is when youngsters drop out school and cannot become gainfully employed. Selling drugs and/or using drugs becomes an alternate route for getting those materialistic things associated with the good life. In Buffalo the largest increase in the mental health population, are people of color in the young period of their lives. In the Buffalo facility, and this is true all over the State when you talk about at-risk populations, they are talking predominantly minority populations. Children are being pushed out of school, as in the city of Buffalo. 619 youngsters were suspended since September, 1990. These were formal suspensions. Out of 619 children suspended, 500 were Black between 13 and 15 years of age. When a child is suspended from school for one to two weeks, they are already having problems because whatever they are acting out due to some frustration, generates a self fulfilling prophecy. You are setting the child further behind in class work and homework and practically declaring this student a drop out. When I called the Buffalo school and asked how many were informal principal suspensions, they told me they did not have the statistics. When I inquired about this at the State

Department of Education, I was informed they were suppose to keep them in school. In Buffalo, they don't keep these statistics and some principals can suspend a youngster up to five days and not have to have a formal hearing. Some come back from this arbitrarily dictated leave only to be suspended again the next week. So many teenagers we see dropping out of school have literally been put out of school. The prophecy has been fulfilled.

In Buffalo we have the highest teenage pregnancy rate in the State of New York. The infant mortality rate for Blacks and Latinos in this State is the highest in the Nation, higher than rates in thirty underdeveloped nations around the world. A Black man in Harlem has a life expectancy shorter than a man in Bangladesh, the poorest nation in the world, and this was before the recent cyclone. We can cite the homeless. We have the highest homeless children population in America and of those children 85-95% are Blacks and Latinos. I visited a homeless shelter in New York City five years ago and it was absolutely horrible to see how those children had to live in the environment of 42nd Street. The drug dealers operated freely within the homeless shelters and hotels and innocent youngsters experienced all kinds of trauma and stress at early ages. Is it any wonder that we get young people who live in a pressured environment with astronomical problems. I don't know whether or not I could survive living in some of these environments that our young people have to live in. Many of you have seen homeless men on the streets. There between 26,000 to 40,000 homeless veterans in this State. 90-94% are Black and Latino. Why is it that Black and Latino veterans who

served in the Vietnam war are disproportionally homeless today? Why didn't they get the kind of quality service available to others who have served and needed help.

When you see a lonely young man out there around their 40's and 50's and you look at him with scorn, remember he may be a man who served in Vietnam allegedly to protect democracy, in a country that we should have never fought in. My only brother served two tours of duty in the Vietnam War, and afterward became a IV drug abuser and died in 1983. At that time I did not know about AIDS, but as they describe his death, I now believe my only brother died of AIDS. So the Vietnam War was not good for anyone. In fact, there were more men who committed suicide after serving in that war than men who died by their own hand during the aftermath of previous wars.

We have a number of people, disproportionately minorities, who are out there needing help. I was informed about a school in my district where it was estimated that 43% of children in that school lived in a home in which the single parent or one of the two parents were substance or alcohol abusers. The problem is how do we work with these children in order to help them cope with the kind of stress and pressure that they endure daily. There is a five year old boy that I bring to my church whenever I can get him to come. His mother is a drug and alcohol abuser. The child loves this lady with a love that I have wished my children at this age could express for their mother. Every time that I bring him to church, he falls asleep within twenty minutes into the service having been up all night because of the activities going on in that house. He is a bright

young man, very street wise but is failing in school. This youngster needs help and society does not provide for him until he gets older and involved in crime. Then you have the criminal justice system waiting there for him.

The issue of minorities in the mental health professions is also reflective of selective exclusion. I would challenge all of you to help us to develop more people in these particular disciplines. I recently spoke at the University of Buffalo Medical School pregraduation dinner for minority students. Out of the nineteen minority graduates with advanced degrees from the Medical School, three were in Psychiatry, two Latinos and one African American. That was a rarity. We do not have many minority graduates coming out of our schools. Selective exclusion as a tool of racism is evident in a number of ways. For example The Graduate School of Social Work in the City of Buffalo was not producing minorities in social welfare. We went to the Commissioner of Social Services for the County, Karen Shifky to discuss the situation and she agreed with me. We then met with President Sample, and the Dean of the School of Social Welfare. We are now beginning to correct the inequity so that the school is welcoming more minorities. I want to urge you professionals out there to visit the schools where psychology and psychiatry is being taught and match the Buffalo lead. Become an advocate for having more minorities enter those fields where minorities are under represented, African American, Latinos and Native Americans. Our populations are growing and our need for minority practitioners is growing by leaps and bounds, as well as the need for innovative programming. Those of you from Buffalo you may have read

recently an article in the Buffalo Daily News, of a program that we started at the Theresa B. Small Health Center where we had nurse practioners examining the high school student at Kissinger High School. A high school that has the highest teenage pregnancy rate and highest sexually transmitted disease rate in the City of Buffalo. If the nurse practitioners suspect a child of being pregnant or having a sexually transmitted disease a recommendation for examination should be made as in the eleven programs like this one throughout the State. Buffalo is the only school district in the State of New York that prevents the nurse practitioner from referring a child to be examined for a sexually transmitted disease or pregnancy. Without the referral or follow up for pregnant adolescents, we deprive her of good prenatal care for a healthy baby. The consequences of this deprivation was the subject for discussions with the previous Mental Health Commissioner in this State. We had an exchange one day in the Office of Mental Retardation about how many youngsters were accepted as clients annually that were low birth weight babies because of inadequate prenatal care and exhibited developmental delays which subsequently lead to OMR admission as they got older. It costs four million dollars in this State to take care of a person who becomes a ward of OMR and remains in the system for the rest of their lives. The great majority of these people were low weight babies because good prenatal care was unavailable.

Your responsibility as mental health people working in our State, is not just the administration of services but to become an advocate for that population. Do not wait until the system has failed the person. Go into the school systems and say, "listen you

need to teach the children about safe sex and about drugs to ensure that they have accurate information so they can make the right decisions when confronted with these problems." Those of you from Buffalo remember reading how I brought 42 professionals to two board meetings of the Buffalo school system to deal with issues of sex and drugs, and we have not been able to move them. I thought the reason why the schools were not teaching sex education was the board composition whose majority is Roman Catholic and was a religious issue. I called Bishop Hare, of the Roman Catholic Diocese, and said Bishop, do you teach about smoking, alcohol, drugs and Aids in the Catholic schools. He said yes, we are suppose to by law. I asked Bishop Hare to send me the curriculum used to teach these subjects in the Roman Catholic schools. Within three hours he had four volumes in my office. To my amazement, the Catholic schools have a fantastic sex education course and when they teach the girls, they invite the mothers to come in. When they teach the boys, they invite the fathers to come in. I said to myself, my God, wouldn't that be wonderful because many of the children in our Buffalo public schools, have mothers who gave birth to them when they were minors. If we were teaching sex education to children in elementary school and invited the parents, it would be very appropriate to educate the parents giving them accurate information they never received.

I challenge you to be an advocate for the endangered population out there. There are activities going on in your community that you can be involved in. There are things you can do such as going to the schools and encouraging the youngsters to enter

careers in mental health. For those of you from Buffalo and especially those who are minorities, we want to start a mentor program in September. We would like you professionals and technicians to come into the schools and meet with 10-15 youngsters one hour a month. Tell them about your profession and of the options available to them. Bring them to your office and explain what you do, and the importance of education for employment in a profession that they will enjoy. It is extremely important that we have role models for our children and we invite people from the White majority to become involved with inner city schools. People who are willing to share information about different opportunities that might be available and of interest to them but they are not cognizant of. One area of the growth is the suburban community where Black professionals are making inroads to share in the American dream of better schools and better housing for their families. That is great but as a result, it robbed the inner city of its most successful role models. What I ask is that you come back and give something back to those inner city communities. Whether or not you are from Buffalo, from another community such as Rochester, those communities need you now more than ever before. I hope that today as you listen to these experts, you see these meetings as the first step in a process of developing greater cultural sensitivity and how we can apply this in the delivery of mental health services. I have had people say that mental health facilities do not understand the culture of the person who comes to them for care, and consequently make inappropriate decisions which are not in the best interest of the client being served.

The last thing I will touch on is how we can impact Albany. You do not impact Albany by waiting until the budget is drawn up. By then, it is too late. You got to meet with your legislators and educate them. Educate them when they are not under the pressure of the legislative session. Meet with them in their own homes or district offices and take the time to organize people in their particular constituencies that you also serve. They will be more amenable to listening by having someone who lives in their district talk to them about the serious issues. Invite them to your institutions and the places you provide services so that they will know where you are located and what you are doing to serve the people. The making of next years budget is going to be a long protracted struggle if you expect to have your issues addressed and programs funded at a higher allocation level than this year's budget. We must organize, mobilize and do the things we do not traditionally do. If we wait until the Governor presents us with another budget, expecting you come down very quickly and try to make things change, it becomes very difficult if we do not have the votes and lobbying resources.

I know most of you earn about 150 thousand dollars a year in this room, so you are making the top dollars. We talk about progressive taxation and taxing those at the top in order to pay their fare share. Toward this end the Black and Puerto Rican Caucus proposed a personal income tax increase where a single person making $90,000 will pay an additional $200 a year. This means they could charge that amount to their Federal income tax and they will come up with a net tax that is less than $150. Should the proposal not be accepted we can expect an increase in property taxes, gas taxes and

all other nuisance taxes that hit the little person particularly hard. There was one fee in the last budget that I didn't even know we had passed because it came up at the last minute. The leadership of the Assembly said well, we have some fees we are going to impose and these will raise $20 million. Nobody said what the fees were because we all paid attention to the big items. When I went to the laundry mat one day, to wash some rugs, the price was going up a full quarter. I said "gee man, why are you going up a quarter?" He said you guys in Albany passed a $12.50 health fee on every laundry washing machine and dryer. I asked him if he was joking--he said no, I have to pay $12.50 for every washer and dryer in this place and so I pass that $12.50 on to the person who use it. Most of the people in the laundry mat were poor people. He probably made $200 dollars more off that quarter per machine but he would only pay out $12.50. He then said I want everyone here to know that this machine here is costing $12 more because of Arthur Eve. There he is--he is your senator. We had a Democratic conference during the week. I said to the Speaker, you rushed to put this together and if you come up with more ridiculous fees which disproportionally hurt the poor, I'm not voting for it. I'm going to talk against it on the floor because I am afraid that the leaders will get their budget people together and come up with another set of those ridiculous fees that they pass on to people.

We brought some of our Caucus budget books which I want to leave with you so you may peruse them at your leisure. Lastly, I want to talk about some of the impact of the Governor's budget cuts on people who can least afford it. I don't know if you are

aware of the Governor's recommendation for a co-payment of fees on medical service for people on public assistance. That means a mother on welfare will have to pay $3.00 for a physician visit. Physicians in this State only get $11.00 for Medicaid visits, the second lowest in the country next to the State of West Virginia. In Connecticut, a physician gets $32.00 per Medicaid visit. In New York, the Governor is now recommending that we take away $3.00 of that $11.00 and have the person on public assistance pays the difference. They do not receive enough to live on, so please become an advocate.

My last recommendation to you is to put God first in your life. That might sound crazy to all you brave people, or psychiatrists. I'm telling you if you put God first and ask God to help you solve some of these problems, I am sure that he will enrich your skills even more.

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